The Primacy of the Nurse in New Zealand 1960s-1990s:
Attitudes, Beliefs and Responses over Time

by

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Abstract

Exploring the past, and pulling ideas through to the present, to inform the future can make a valuable contribution to nurses and nursing in New Zealand. By gaining some understanding of the attitudes and beliefs nurses held, and how these influenced their responsiveness, we can learn what active responses might help inform our future. Nurses in New Zealand, as individuals and within the profession as a whole, reveal the primacy of the nurse – nurses who have made and can continue to make a difference to the health of the peoples of New Zealand.

A hermeneutic process was used to interpret material, from international texts, national texts and public records over four decades, the 1960s to 1990s. This was supplemented and contrasted with material from twelve oral history participants. Analysis of the material led to the emergence of four themes: Nurses' decision-making: changes over time; An emerging understanding of autonomy and accountability; Nurses as a driving force; and Creating a nursing future. These four themes revealed an overall pattern of attitudes, beliefs and responses of the New Zealand Registered Nurse. The themes surfaced major revelations about the primacy of the nurse in New Zealand, nurses confident in their ability to take the opportunity, seize the moment, and effect change.

The contribution this thesis makes to the discipline of nursing is an understanding of how the nurse actively constructs the scope of a professional response to the context. The thesis demonstrates how nurses can learn from the past, that the attitudes and beliefs that underpin our active responses can either move us forward, or retard our progress. As nurses we can also learn that to move forward we need particular attitudes, beliefs and responses, that these are identifiable, and are key factors influencing our future, thus ensuring the continued primacy of the nurse.

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Colleagues provided valuable feedback and helpful suggestions at the research schools, made me appreciate being part of a wider group seeking to share and explore issues pertaining to nurses and nursing, and in both formal and informal general discussion on the topic.

I am also grateful to the Nursing Education and Research Foundation (NERF) who assisted me with a financial grant that enabled me to purchase a quality tape deck for the interviews, some of which will be included in the NERF oral history archive.

The Primacy of the Nurse in New Zealand 1960s - 1990s: Attitudes, Beliefs, and Responses over Time.

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Key to frequently used abbreviations

ICN	The International Council of Nurses.
NERF	The Nursing Education and Research Foundation.
N & M Board	Nurses and Midwives Board (renamed the Nursing Council of New Zealand in 1972).
NZNA	New Zealand Nurses Association (from 1971 to 1993).
NZNO	New Zealand Nurses Organisation (from 1993 to present day).
NZNJ	New Zealand Nursing Journal .
NZRNA	New Zealand Registered Nurses Association (from 1934 to 1971).
NZTNA	New Zealand Trained Nurses Association (from 1909 to 1934).
R.N.	Registered Nurse.
R.G.N.	Registered General Nurse.
R.G.O.N.	Registered General and Obstetric Nurse.
R.Cp.N.	Registered Comprehensive Nurse.
SANS	School of Advanced Nursing Studies (previously known as the New Zealand Post Graduate School 1928 to 1970).
WHO	World Health Organisation.

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The referencing style used for the participant's accounts

1. Direct quotations from the participants are in *Italics*, and use their full name. For example (*Lee Mathias*).
2. The reference at the end of a quotation identifies the interview number first then the transcript page number. For example (2:6) means second interview, transcript page 6.
3. The quotation will be acknowledged either in the text immediately above or at the end of the quote using the participant's name and details of the interview and transcript page. For example (*Lee Mathias, 1:7*).
4. *[Text inserted]* is used to clarify a quotation where it may be unclear to the reader.
5. Words or phrases emphasised by the participants are in bold. For example (*I mean I **know***).

Chapter One – Why the primacy of the nurse?

In preparation for the year 2000 many people are thinking about the future. This includes nurses nationally and internationally. As someone who has lived and worked nationally and internationally during the last four decades, I have a sense of the significance of the past for the future. As I consider what the next millennium might mean for nurses and nursing I believe that exploring the past, pulling ideas through to the present, to inform the future would make a valuable contribution to nurses and nursing in New Zealand.

The **first premise** in this thesis is that we (the nursing profession) can learn from the past. That by gaining some understanding of what attitudes and beliefs nurses held, and how those attitudes and beliefs influenced their responses, we can learn what could be helpful for our future. To explore the premise that we can learn from the past, we need to obtain information from the past. An environmental scan of the period enables a picture of the context to be built. The robustness of the scan depended on a variety of perspectives and included written and oral texts to assist the dimensionality of the process.

In seeking oral texts I chose twelve nurses who illustrate primacy, who each had powerful influences in planning, policy and politics (in the broadest sense) over the four decades. They learned how to effect change, and were able to articulate what they did, and why and how they made a difference to the health of the peoples of New Zealand. They were also able to comment on how they thought nurses could continue to make a positive contribution in the future. Their influence was from a variety of experiences, and occurred in a variety of settings. Given an understanding of the context of the time period, the group enabled me to explore some of the key events that occurred in New Zealand nursing, to gain some

understanding of their attitudes, beliefs and responses over time, and to consider how we might learn to inform our future.

The **second premise** is that the voice of nurses themselves, from written and oral sources, is capable of revealing something about how their attitudes, beliefs, values, and understandings influence their responsiveness. From this premise it is possible to explore what, why and how such influence occurs. This thesis demonstrates that while the influence of the nurse can be at both a macro and a micro level, there are key attitudes and beliefs that underpin our responses. Some attitudes and beliefs enable the nursing profession to move forward, to effect change and to make a difference to the health of the peoples of New Zealand, while other attitudes and beliefs retard progress and have a negative effect on nurses' potential contribution.

The **third premise** is that the specific influence and contribution of individual nurses and the profession as a whole enable nurses and nursing to move forward. It is the action nurses take (or do not take) in relation to nursing issues that is the key influence. It is their active responsiveness to the context that makes the difference. Primacy of the nurse is about the important influence of the nurse – the way a nurse actively responds – the essence of making a difference. Certain attitudes and beliefs that demonstrate the primacy of the nurse underpin their active responsiveness.

If the primacy of the nurse is the key feature in moving forward, I needed to explore if this is indeed the case. The material gathered from the sources enabled me to sift and lift certain key events, changes, developments, and issues that effected the New Zealand nurse as an individual or as the profession as a whole. By exploring at a deeper level, it was possible to discover what New Zealand nurses did, and how and why they responded in particular ways. As a feature of our history, both

nationally and internationally, nurses in New Zealand have made significant progress, and moved forward, when we have been actively responsive in effecting change.

While the focus of this thesis has its emphasis on the New Zealand nurse, it is clear to me that nurses in New Zealand are no different in this respect from their international colleagues. Nurses all round the world both as individuals and as a profession have made and can continue to effect change making a positive contribution to health care.

By exploring major trends it is possible to demonstrate how the nursing profession in New Zealand responded to the 'big picture' events. A variety of reasons influenced whether the response was one that moved nursing forward, maintained the status quo, or even hindered progress.

Reasons for choosing the time period: 1960s–1990s.

I have defined 'the past' as the time period of the 1960s–1990s. This time frame was carefully considered, with three important reasons influencing my choice.

The **first reason** is that this period is familiar to myself as the researcher, as it covers the time I have been actively involved in nursing. I began work as a nurse in the 1960s and apart from a short period taking care of two children at home, I have worked as a nurse over the four decades. I am currently involved nationally as a facilitator of programmes associated with leadership potential, and internationally with the International Council of Nurses (ICN) – an international federation of national nurses associations in 122 countries. For me, my experience over the four decades saw me working in the late 1950s and 1960s as a student of nursing, a Registered Nurse (R.N) in practice, and as a nurse educator. In the 1970s and early 1980s I worked as a post graduate student, a nurse educator, a leader in the nursing educational field as a senior member of

staff in a postgraduate nursing programme in the tertiary education setting. During the late 1980s and 1990s national activities included work as a leader in national nursing politics. International work was with ICN related to socio-economic affairs, constitutional change, leading a task force on structural change, and assisting with policy direction on the executive of the ICN Board. The national involvement in nurses, nursing and health have provided the opportunity to meet many nurses and community leaders over this time period, and to maintain contacts and friendships over many years. Internationally I have had access to research on a wide policy front and to environmental scanning on a worldwide basis. This familiarity with the events, the context, the people, and the 'movers and shakers' during the past four decades provides me with the motivation and a special lens through which to critically examine and interpret the meaning and understandings that unfold.

The **second reason** is that contextually the 1960s-1990s recognised the Registered Nurse in New Zealand as the primary caregiver in the hospital setting. Clinical practice, the real core of nursing, was acknowledged as the legitimate business of the R.N, the 'heart and the pivot of nursing' (NZNA, 1984, p.39). The Registered Nurse changed from predominantly being a supervisor of student caregivers in the 1960s and 1970s, to the primary care giver in the 1980s and 1990s. The development of a satisfying and valued career in clinical practice became a reality for the New Zealand Registered Nurse. This change over time illustrates the responsiveness of the nursing profession to increasing demands for a skilled professional practitioner as the health care setting became more acute and an increasing level of competence was required from the nurse.

The **third reason** is that nurses are available now who have lived and worked during these four decades, who made an impact and carry with them wisdom that is unlikely to be found in written sources. Many of these nurses still work in the nursing or health sector and are able to share

their knowledge of this period of major change. I believe this needs to be recorded before the collective memory of these nurses is diluted. Nurses in New Zealand are not well known for their academic writing, let alone recording important events from the past. While there are nurses around now that can help record the events that have affected nurses in New Zealand, every year of delay in recording their memories may mean the significance, impact, and memory of events are forgotten.

Positioning the thesis

This thesis is a nursing thesis. Procedurally the use of written and oral texts has been informed by some tenets from hermeneutics and oral history with a view to building up an interpretive strategy that enabled sufficient meaning and understanding to bring past insights and observation through to the present and reveal possibilities for the future.

The research question began from a personal interest in the many changes affecting nurses and nursing over time and a broad base of inquiry into the possible factors influencing the practice and beliefs of the New Zealand R.N. Some early questions raised included what were the important nursing landmarks over the four decades? What were the changes in practice and beliefs of the Registered Nurse in New Zealand over this time? Do they tell the nursing profession anything about determining likely futures?

These questions were linked to my thoughts at the beginning of the research when I asked myself how nurses in New Zealand could learn from the beliefs and practice of nurses in the past, to create a positive effective nursing future?

There is precedence for a past-present-future focus and the idea of the past informing the future is a common thread for a number of nurses who write about exploring and reconstructing the past. This can apply to the

individual as well as to the profession as a whole. If we miss opportunities for growth and change, if we fail to move forward, in the end we fail the society we seek to serve. Newton, an American nurse writing in 1965, suggested that we have ignored the importance other professions such as medicine, law and education place on the way in which knowledge of their past has guided and inspired their forward movement. She described some of the many roles such studies can be assigned - “guardian of tradition, guide to the present, creator of the future, and inspirer of nations” (Newton, 1965, p.20).

Hamilton (1993), an American nurse writing about nursing’s past, suggests that the value of understanding our past is a way of demonstrating the living force of our existence.

For nursing, an understanding of the profession’s past can provide an analysis of its beliefs, leaders, institutions, work, in a way that demonstrates that nursing as a set of ideas is a living force of continuous existence.

(Hamilton, 1993, p.45)

Seeking to gain understanding of and give meaning to the past provided me with an opportunity, an opportunity to reflect on past beliefs, institutions, leaders, to reconstruct past events, to interpret the past in a way that could assist nurses to understand and give meaning to nursing. The knowledge of the past and the context of the present enabled me to reflect on the now, and consider implications for the future.

It also prompted me to ask questions. What is happening to nurses and nursing and why is it happening? What is the living force of nurses and nursing? How have attitudes, beliefs and responses changed over time, and have nurses in New Zealand used the past to inform our present? What are the attitudes, beliefs, and responses that would enable nurses and nursing to move forward? Moving forward indicates an intention to

prepare for and create our own future, to scan our environment to consider the likely challenges, and to strategize using possible scenarios.

Recognising then that our past can guide and inform our future, this study seeks to examine the past, to broadly explore across four decades to the present time.

Thesis style and flow

In writing this thesis I have used a mixture of the first and third person. Reading other theses, discussions with colleagues, and writings addressing this issue support this decision. The use of the first person in academic writing is appropriate in qualitative and interpretative research where an author is giving a personal judgement arrived at on the basis of reasonable evidence (Webb, 1992). In writing of my personal experience or opinion, and the role played in shaping and interpretation of the data and ideas, I have used the first person.

I also recognise that the nursing community is diverse in attitudes, beliefs, and practice responses however I have chosen at times that seemed appropriate to use the collective terms 'our', 'us', and 'we' when referring to nurses in general, or the profession as a whole.

While acknowledging that the term 'patient' is controversial for some in the 1990s, to be consistent I have chosen to use 'patient' in this study when referring to an individual receiving health care, rather than the terms 'patient/client' or 'client' other than when quoting from a text or participant.

The term 'nursing practice' is also controversial. For some it is synonymous with clinical practice, and many of the quotations and references used in this thesis use 'nursing practice' in this sense. For others 'nursing practice' covers the entire range of the art and practice of nursing wherever nursing occurs. My personal view coincides with the

latter perspective. Throughout this thesis the term 'nursing practice' is used generically, and I have used the term 'clinical practice', for example, wherever it is clearly differentiated from other forms of practice such as nursing education.

The tertiary institutions offering nursing programmes since the 1970s have had several name changes over time. While some institutions were referred to as 'technical institutes', the majority were referred to as 'polytechnics'. I have chosen to use the latter term when referring to these institutions collectively.

I have also adopted the style of the ICN constitution in the use of the singular (nurse) serving also for the plural, and the feminine (she) for the masculine, according to the required context (ICN, 1998, p.2).

In seeking to present the ideas in this thesis I have worked to craft the line across eight chapters each picking up the argument from the previous chapter. The flow of the work begins introducing the work in this chapter, the emergence of the research question being addressed, and positioning the study. The writing in chapters two and three is both summative and descriptive, threading together selected information about the period and processes used in the study. The latter chapters work to synthesise the source material from the written and oral texts linking and building on the themes to reveal the primacy of the nurse during the four decades.

Chapter Two is the methodology chapter. I have chosen to place this chapter at the beginning of the work as it is key to understanding the creation of the account to follow. The methodological principles guiding the approach to the thesis are outlined, including the assumptions associated with the use of oral history as method. An interpretive framework adapted from J.G. Droysen is used to describe the research process using five steps, from pre-understanding through to the process of creating the account of the work.

The metaphor of the quilt is explained, along with an introduction to the nursing context chapter and the four theme chapters. The methodology concludes with an outline of the assumptions and limitations of the study.

Chapter Three is the nursing context chapter. As indicated previously if the premise is that the nursing profession can learn from the past, we need to obtain information from the past. The context provides background for the time period of the study and is an important platform for bigger questions to follow. An opportunity is provided to explore the past, and begin to unfold evidence of the importance of the influence of the nurse. The chapter includes the beginning of the revelation of the participants' voices, complementing the material from the written texts and providing examples of how nurses effected change over time. Because the theme chapters are built on an understanding of the nursing context, it is important to provide a detailed, thorough background which informs both the unfamiliar reader, as well as the reader with an interest in contextual influences affecting nurses and nursing. Significant events over the four decades are identified and examples given of how individual nurses and the profession influenced change in areas of nursing education, nursing practice, and nursing regulation. Because of the influence on the profession as a whole, I have also included the role of important New Zealand nursing organisations, as it was often through these organisations that the profession effected change.

Chapters Four to Seven are the theme chapters, where the pattern of attitudes, beliefs and responses relating to the four key themes are outlined: 'Nurses' decision-making: changes over time'; 'An emerging understanding of autonomy and accountability'; 'Nurses as a driving force'; and 'Creating a nursing future'. Each theme builds on the one before, to build a clear picture of the powerful influence of the nurse over the four decades and revealing the primacy of the nurse.

Chapter Four: 'Nurses' decision-making: changes over time'. The first theme to emerge is the centrality of the concept of decision-making. How attitudes, beliefs and responses to decision-making change over the four decades, is described in this chapter and how while in the 1960s, students followed standard lists and protocols of care almost without question, and applied these lists to all their patients without taking individual needs into account, the provision of care was very different in the 1990s. Changes occurred over the four decades that led to an individual professional nurse using her professional judgement for each individual patient with a clearer idea of the boundaries within which nurses legitimately made nursing decisions. Exploring how nurses learned to make decisions through the voices of nurses themselves (in the written and oral texts) provides greater understanding of how nurses' attitudes and beliefs influenced their responsiveness.

The role of decision-making is clearly demonstrated as a key influence if the nursing profession wishes to move forward, while evidence is provided of the attitudes and beliefs that underpin effective decision-making, through the written and oral texts and a sample of participant vignettes.

Chapter Five: 'An emerging understanding of autonomy and accountability'. This theme outlines the specific influence and contribution of individual nurses and the profession as a whole building on accepting accountability and responsibility for the decisions made. These concepts have emerged as part of the development of the profession in New Zealand from the early 1970s. The suggestion that effective decision-making skills on their own may not be enough is explored. The acceptance of accountability and responsibility for decisions made is an important hallmark of a professional and enables the individual and the profession to grow. Understanding the concepts of accountability and responsibility is linked to the professional development of nursing

practice as outlined in the context chapter, and again utilises material from both written and oral sources. The concept of autonomy is more complex. Why autonomy is so complex, and what the nursing profession can learn from past debate and possible unquestioning acceptance of the term in relation to our role in clinical practice is outlined.

Chapter Six: 'Nurses as a driving force'. The idea of nurses as a driving force emerges from the previous two theme chapters. It begins to circle around connecting back to decision-making and autonomy and responsibility. The questions raised in this chapter link to the impact of the nurse and the case is made that those who wish to effect change, to motivate, to move forward, must not only be effective decision-makers, accepting accountability and responsibility for their decisions but they must also take action. Individually or within the profession, they drive and make things happen. More of the participants' voices are used than in the previous two chapters, with stories of themselves as drivers or of nurses they knew as drivers, nurses who took action and effected change. The primacy of the nurse becomes explicit in this chapter.

Chapter Seven: 'Creating a nursing future'. Grasping that primacy is the essence of effecting change, and understanding that the 'how' of primacy will help nurses create a possible future, this chapter is about how we can utilise past insights in the present and reveal possible futures. It enabled me to explore the lessons and legacies as identified predominantly by the participants and to consider how the nursing profession can inform our future from these lessons and legacies. The primacy of the nurse over time, in the sense of nurses taking opportunities to change and grow, seizing the moment to act and make things happen, or making a difference has been revealed in the previous theme chapters. The importance of the primacy of the nurse is identified alongside the attitudes, beliefs, and responses that we can learn from the past, utilise in the present, and inform and guide a positive future for the nurse.

Chapter Eight concludes the thesis. All the threads of the pattern of the quilt metaphor are drawn together. The contribution of this thesis to the discipline of nursing is outlined, and a summary of how the profession can ensure the continuing primacy of the nurse and by implication enhance nurses' contribution to the health of the peoples of New Zealand.

Chapter Two: Methodology

We use past knowledge to interpret that window of experience to place momentary fragments within large wholes that give them a function and a place. [The fragments] will remain meaningless if they continue to be nothing but coloured flecks or mere sequences of letters or words.

(Hirsch, 1987, p 48)

The methodological basis underpinning this study is outlined in this chapter building on the belief that the oral and written voices of nurses can reveal something about how their attitudes and beliefs and understandings influenced their responsiveness. It enabled me to make explicit how the nursing profession can learn from reflections and experiences, and to explore and create new understandings about the attitudes, beliefs, and responses of the New Zealand R.N.

The rich and fascinating pasts of both individual nurses and the profession of nursing have been recognised internationally as well as nationally by social historians, public policy analysts, writers of women's history, but only recently by nurses themselves (Bridges, 1967; Brush, 1999; Coney, 1993; Hyman, 1982; Lynaugh & Brush, 1999; Sargison, 1986; Tallberg, 1995).

Chinn (1990), as editor of the American journal *Advances in Nursing Science*, suggested that like the stories of women's pasts, the past records of the activities of nursing and nurses are confined by two persistent and interrelated social processes: invisibility and stereotyping. These two notions are also mentioned in New Zealand writing (Bickley, 1983; Instone & Stevens, 1987; Perry, 1993; Wootton, 1987).

Chinn claims that most of the history currently written about nursing fails to help us learn about nurses as people.

We learn very little or nothing about nurses as people – their motives, ideas, personal values, how they viewed the circumstances of their lives. The contexts of their lives are often missing, or portrayed from the limited perspective of the present day author.

(Chinn, 1990. p.viii)

While New Zealand nurses to date have not been prolific writers or recorders of their past, this is beginning to change, influenced by the relatively recent developments of graduate educational opportunities for the nurse, the requirements for nurses to write as part of their studies, and the focus on nursing research as part of the work requirements for the nurse educator. Internationally the study of nursing's past "became a series of chronologies, myths, and legends that served to venerate nurse pioneers but lacked the vital transfusion that gave nurses an understanding of their social mission" (Hamilton 1996, p.5). In a similar vein, much of the work in the past recording the history of nursing in New Zealand was limited to factual data about organisations and events related to nursing (the history of NZNA, the history of a school of nursing, the history of a particular hospital), or about past nursing leaders (Mary Lambie, Grace Neill, Hester Maclean).

Hamilton (1996) suggests that over recent years when studying our past, the nursing profession has moved forward, past the chronological events to consider a wider range of issues including how we think – more towards writing about nurses as people.

[We have] moved past chronologies, to analyse nursing's legacy of domesticity, complexities of international nursing, the advance of intensive care nursing, racial concerns within nursing and the influential thinking of important actors within nursing.

(Hamilton, 1996, p.5)

This thesis is not about documenting a chronological account of events over the past four decades. It is, however, about exploring and thinking about the importance of actors in influencing events and movements within nursing. This is achieved by identifying what is available in written texts about nurses' thoughts and beliefs, as well as exploring the experiences of nurses living and working over this time period.

This thesis uses historical material such as oral history, archival and written texts, not to craft an historical account, but to explore and seek to answer the question about what the profession can learn from the past. This is done within a framework, guiding interpretation of the material, to explore trends and movements that characterise the period, the experiences of nurses and how they effected change over time.

Before describing the framework and processes used, a number of underlining principles are outlined that I have used associated with ways of seeking to understand the nursing world via its past, understanding that was continually evolving.

Methodological principles

In the previous chapter I identified that this thesis provides an opportunity to explore the premise that we can learn from the past to guide and help create our future. To learn from the past I needed access to multiple sources, especially access to the nurses' voice through oral history interviews and written texts. To progress the question of this inquiry, it

was important to develop some principles to guide the methodology of the thesis and develop an overall framework.

I sought to gain meaning and understanding of the past of the New Zealand nursing profession to reveal trends and patterns that could inform us in the present, and prepare us for the future. To do this I needed to consider what sources would be helpful in this exploration, and what processes would be most effective.

Several methodological principles were identified to guide my approach to the development of a framework and the process of gathering and analysing the material.

The **first principle** was the need to be open and responsive to other points of view. While material can be gathered from a variety of sources and perspectives, I needed to be cognisant of the diversity of backgrounds and experiences and the likelihood that viewpoints will differ. Indeed Gordon Leff (1971), an English academic, considers an understanding of the absence of uniformity in human affairs central to human studies.

Teresa Christy (1975), an American nurse addressing the need to explore differing views, emphasised that those writing about the past must be like a detective – developing curiosity, perseverance, tenacity and scepticism. The need to be open and responsive to other points of view is seen as a necessary approach to the evidence a researcher gathers in endeavouring to fill in the gaps in the topic being studied.

In constructing reality to give meaning to peoples' lives, it is sometimes difficult to recall past events as they actually occurred. Issues such as knowledge of the time, the place, the context, the personal background of the person involved all impact on what the final account may be. Taking notice of different viewpoints and considering what they might mean is part of the rigour required in data analysis. Gathering material from a

diversity of written and oral texts increases the possibility of receiving such a cross-section of points of view, and leads to the next principle.

The **second principle** was the need for access to a wide variety of sources about the past. It was not appropriate to follow a single line of inquiry, I needed to explore ideas widely when searching for broad patterns and trends, to add robustness to the research. Chick (1997), a New Zealand academic, writing about a New Zealand collection of historical essays, suggests that it is rare for there to be a single truth “more likely [there] are multiple truths, depending on whose voice and view is allowed to shape the narrative” (Chick, 1997, p.1).

Because of the complexity and diversity of nursing practice, there are many sources of information in both the public and private arena. Written sources often provide the ‘big picture’ view, the ‘official’ view, an outline of events deemed to be significant by those in authority or those with special interests. Such sources can be both national and international, or the views of the profession as a whole as opposed to the view of the individual practitioner. Written sources can also be supplemented by oral text, the latter providing more specific detail or the personal perspective of those present at the time. I needed to find ways to access the wide variety of voices that had something to say about our past.

The **third principle** was that there is always the possibility of new information, or new understandings. The diversity of understandings and their value-laden nature support the view that a multiplicity of equally plausible understandings is both possible and legitimate (Heller & Porro, 1987; Tosh, 1993). Contemporary approaches to the study of the past focus on history as a human science, with life as an interpretive event, full of complexity and diversity and essentially contextual (Marius, 1995; Tosh, 1993). This involves gathering evidence about people, places and

events and seeking to interpret, understand and give meaning to that evidence.

In linking understanding with meaning, as human beings, our very ability to understand depends on our participation in contexts that enable us to make connections with past understandings and to give meaning to a new event.

To understand is always to understand differently. What the “things themselves” say will be different in light of our changing horizons and the different questions that we learn to ask. Meaning is always ‘coming into being’ through the ‘happening of understanding’.

(Bernstein, 1983, p.183)

Again the rich sources of written and oral texts provide the possibility of new understandings, and understanding differently. Texts written about a particular event from a variety of perspectives enable us to see that event through different eyes. For example the management team restructuring a health service would see the process very differently from the perspective of the staff providing direct patient care. Similarly oral history interviews can provide varying views. For example the nurse involved in the politics of planning the change of the transfer of nursing education to the tertiary education system would have quite a different story from that of a nurse uncertain of the effects and resisting the change, or the nurse teacher given the opportunity to implement the proposed changes. The opportunity to explore similarities and differences within and between texts assists our understanding. Again this can be about pulling pieces of the past together through to the present in order to inform the future. When endeavouring to put the differing pieces of evidence together, I will in effect be reconstructing my understanding, the focus of the next principle.

The **fourth principle** was that methods used to study the past involve the hermeneutic of actively recreating or reconstructing the past. Gaining understanding of what happened, or the significance of some action or event, requires an act of interpretation. Norman Denzin cited in Sandelowski (1991) proposes that all interpretation (even scientific explanation) involves human fabrication. I would be using my thinking, my imagination to put together the whole, to use a hermeneutic process to bring congruence to my understanding. Hermeneutics is the term used to describe the art of understanding and interpretation that are concepts important to this thesis. Emile Betti (1972), a German philosopher, in writing about hermeneutics, which he defined as the theory of interpretation, described his belief that the interpreter's attitude cannot be merely receptive, but has to be actively reconstructive.

The hermeneutic process, as used in the framework of this thesis, was a process where every effort was made to understand the various meanings and intentions of the written and oral texts. Evidence is always partial, fragmentary, and incomplete, and required me as the researcher to endeavour to arrive at an understanding of how pieces may or may not fit together. To gain new understandings and then reconstruct the account. Interpretation and understanding can be said to move in a circular manner, starting with my own self-knowledge and pre-understanding and eventually arriving at a deeper understanding on which to continue to build.

The **fifth principle** was to seek to know the nursing world better through a process of understanding by means of investigation, rather than through a process of causal explanation. Wilhelm von Humboldt, a pioneer of libertarian ideas in the nineteenth century, described the task of the enquirer as supplying the inner coherence, uniting individual events without which the events would be meaningless. Those who followed Humboldt's approach sought to understand the world as produced by

human beings, through a process of understanding, rather than a process of causal explanation. Humboldt has been referred to as ‘the Bacon of the historical sciences’ (Droysen, 1958, p. 324) and Droysen saw his own work as an application and elaboration of Humboldt’s ideas. Droysen (1893) proposed a method of studying the past that sought to gain “forschendes verstehen” (understanding by means of investigation). He emphasised the methodological steps necessary for understanding, and described the task of history as elucidating the present in the light of the past.

The methodological steps of investigation used by Droysen were adapted to form the framework of this thesis.

The **sixth principle** was that the use of oral history as method could provide access to that past, present and future lens that often enhances our understanding. Fyfe and Manson (1994, p.1), New Zealand oral historians, describe oral history as “a record of information gathered in oral form usually on sound tape as a result of a planned interview.” While many link oral history to historical research, oral history itself may be used in other forms of research where participants offer a personal perspective to guide and enhance understanding of the topic under study.

Thompson (1988) reminds us that many written sources were oral in origin. The fifth century Greek historians Herodotus and Thucydides used oral tradition and information collected personally from informants, moving from orality to literacy. Oral sources continued as an important primary source until after the Renaissance. Written sources grew in importance in the nineteenth century, with the advent of modern academic history that was primarily document-based. The use of oral sources was largely abandoned by Western historians about this time (Hutchings 1993). Indeed Tosh (1993), stated that Arthur Marwick, a major writer in the

area, in his 1970s book titled *The Nature of History* did not even mention oral sources in his list of primary sources.

Within this sixth principle guiding the methodology, there are three key assumptions regarding the use of oral history in this inquiry. The **first assumption** was that the oral texts of the participants in this study would add a perspective that was not readily available in the written texts.

While oral evidence requires critical evaluation and needs to be deployed in conjunction with other available sources, Henige (1982) suggests, however, that in integrating oral and written data it is rare to find substantial similarity. The two sets of data (oral and written) can range from being nearly identical, complementing each other, contradicting each other and being so different that there are almost no common features. Lummis (1987) proposes that while written and oral data both have their strengths and weaknesses, the value of oral evidence as a historical source must ultimately be established within its own authenticity. If each piece of oral evidence needs to be corroborated by written documentary sources, he suggests that one might as well just use the documents. The idea of oral history as an additional source of data is supported by Henige (1982), suggesting that oral historians are the greatest “adders” since virtually none of the material they use was accessible before their research.

A major contribution of this thesis was revealed when considering this assumption. The theme chapters outline clearly that the written texts only revealed half the story about an event or activity. It was through the accounts and experiences of the participants that a deeper understanding of the ‘why’ and ‘how’ emerged.

The **second assumption** was that oral sources enable the researcher to explore events through the experience of those present at the time. Portelli (1991) suggests that oral history has a ‘different credibility’, a different perspective from written sources, as it tells us less about events

themselves than about the meaning of those events through the experiences of those who were present. “The importance of oral testimony may lie not in its adherence to fact but rather in its departure from it as imagination, symbolism and desire emerge” (Portelli, 1991, p.50-51).

The **third assumption** was that it was not the size of a group of informants that is important but the fact that the participants are ‘knowledgeable’. Writing about the use of participants and the use of oral texts, Blumer (1979) discussed the issue of representativeness. Using the example of Thomas and Znanieckis’ study, *The Polish Peasant in Europe and America*, he suggested that the researcher should seek key informants who have a

profound and central grasp of a particular cultural world...[and that] half a dozen well informed people with such knowledge [of the event under study] constitutes a far better representative sample than 1000 people who were involved but not knowledgeable.

(Blumer, 1979, pxxxiii)

To be knowledgeable about the events implies some pre-understanding that can then be used to assist to interpret changes and develop new understandings. Morse (1994) supports the need for informants to be knowledgeable and experienced in the field alongside an ability to reflect and to be articulate. Hutching (1993), a New Zealand writer, in her short guide to oral history cites Willa Baum, an experienced oral history practitioner, who also emphasises the importance of interviewee knowledgeability. Oral history

involves the tape recording of an interview with a knowledgeable person, someone who knows whereof he speaks from personal participation or observation about a subject of historical interest.

(Hutching, 1993, p.5)

My personal experience would support the value of the perspective of the knowledgeable participant. In discussing the past with colleagues or friends it was very clear to me that if the participants in this study were not present or involved in some fairly significant way it could be difficult to comment with some degree of credibility.

The methodological principles clarify how I have approached the development of the framework and process used. They also make explicit the basis of the assumptions underpinning the work.

Introduction to the framework

Having established that this study was about building an inquiry into nursing relating to the factors influencing the attitudes, beliefs and responses of the Registered Nurse in New Zealand from the 1960s to the 1990s, the next task was to create a framework and process that would enable the emergence of meaning and understanding, through interpretation and analysis of the source material.

While searching for how writers and researchers did this I found two particular writings that were to influence the analysis of my material, and help develop the framework and process.

The first influential piece of writing was in a study guide on aims and methods of the human sciences by Veit-Brause (1980), an Australian philosopher interested in the history of ideas. In reading about interpretation, meaning, and understanding, I found a hermeneutic method developed by Veit-Brause illustrating the steps of interpretation outlined by Droysen. In explaining an exercise with the interpretive task of understanding the elements of hermeneutic historicism, she described a method, based on Droysen's interpretive framework, which utilised a number of steps of interpretation and applied knowledge of the past to a judgement about the present and future developments.

While the Veit-Brause material was dated, published and written for an undergraduate course in philosophy, I found the concept fitted the ideas I wished to explore – using knowledge of the past to inform the future. The adoption of Droysen's approach by Veit-Brause is adaptable to the knowledge and general hermeneutic of interpretation, meaning, and understanding as applied to the many sources available in relation to nurses and nursing. While more contemporary sources suggested other approaches I chose to develop a framework from this flow of ideas.

The second influential writing was a book edited by two New Zealand historians, Frances Porter and Charlotte Macdonald, (1996) titled *My Hand Will Write What My Heart Dictates* about the unsettled lives of women in nineteenth century New Zealand as revealed in their letters and diaries to sisters, family and friends. It was in the introduction to the book that these authors described an approach that led to the quilt metaphor described later in this chapter.

From both these writings, I adopted a general hermeneutic theoretical position, the metaphor of the quilt, and created a framework for analysis of the source material.

This interpretive framework informed by Droysen was consistent with the six methodological principles, and the three assumptions regarding oral history. It comprises five sequential processes, which are briefly outlined below and detailed later in the application of the framework. The framework was used to background the nursing context and explore the experiences of nurses during the time period and was informed by the methodological principles mentioned earlier in this chapter.

The framework, its processes and the research question

A strategy was developed to answer the research question by means of investigation and being actively reconstructive. The questions stated in

chapter one served to create a substantive base that became the guiding questions that led me through the diverse source material. I was concerned to address what understandings we could gain by exploring the attitudes, beliefs, and responses associated with nurses and nursing over four decades.

The adoption of the Droysen framework to work with the material led to five sequential steps - building and clarifying pre-understandings; developing understanding of the context; exploring understanding in relation to source material; the development of more complete researcher understandings; and using this information to create an account.

It became clear to me that working with pre-understandings would be a challenge because of my history and position in national nursing politics. I needed to be open and responsive to other points of view. Understanding the context covering four decades would be challenging enough in itself let alone endeavouring to gain a fuller sense of the nursing context. It would require much searching and reflection to obtain an accurate timeline as a base, and an idea of the relationships between national and international perspectives and local pockets of difference, and the influence of individuals and the profession. How would I be able to place the attitudes and beliefs described by the nurses alongside the context?

To understand the source material required access to a wide variety of both written and oral texts. It was clear that written text alone could not answer the question about nurses' attitudes, beliefs and responses. The use of oral texts could supply access to the necessary past, present and future lens as well as exploring both professional and individual understandings. Researcher understanding would mean interpreting the material and actively recreating or reconstructing the past to arrive at a deeper level of understanding. I would then be in a position to create the account.

I felt confident that the framework was robust enough and would work in a way that provided the correct level of intellectual rigour to pursue the question, to clarify the material and to surface the attitudes, beliefs and responses needed to establish lessons and legacies nurses need to consider to inform our future.

The next section briefly describes the five-step process, prior to writing about the methodology in action.

The five step process.

Pre-understanding.

We start our historical interpretation from our own self-knowledge and pre-understanding of what it is to be a human being. And we arrive, in the end, at a deepened awareness of our own situation, which, presumably, could become the starting point for a further attempt at understanding the historical world more thoroughly.

(Veit-Brause, 1980, p.69)

The first step in the process of pre-understanding involves exploring the basis of the research question and what contribution such a study could make to the discipline of nursing. What were the pre-understandings and ideas that might be taken for granted drawn from existing knowledge of the period and personal perception of the events that were important? This would involve the process of identifying, clarifying, and narrowing the field in relation to the thesis question; positioning the context against particular events and issues of the day; documenting what was already known, and challenging those positions in light of methodological principles such as being open to new and diverse perspectives.

Understanding and context

Jolley (1993), a UK nurse educator, suggests that we need to be aware of contextual influences of the past to understand how traditions come to be shaped and moulded.

It is necessary to consider in a little detail the social structure and cultural context of the period. Political and economic, as well as social and environmental factors, exerted powerful influences then [in the past] as they continue to do in the present era, and nursing in common with most other occupations is not immune to these.

(Jolley, 1993, p.1)

This second step in the process is about gaining an understanding of the context of the time period. It would require reading widely about events that occurred during the period of the study and recording key influences as perceived by the researcher. It would also require time for reflection, dialogue, and time to consider the socio-political climate of the time period, identifying the leaders or people of the day who made a difference - what they did, and how and why they responded in a particular way.

Understanding and source material

Building on the premise of needing access to a wide variety of sources, the third step of the process requires attention to be given to what the most appropriate sources might be. Material needs to be found from sources that provide access to differing viewpoints, to begin to understand the multiple realities that are always present.

Relevant sources need to be sought with the intention of building diverse understandings and exploring events from the perspectives of those relevant to the study. What sources would be useful to provide diversity? What sources are available relevant to the time period under study? Should the sources be both oral and written texts?

Understanding of the origin or status of sources are also important, for example, questions about written texts might include details of the author, the intent of the writer, whether the writing fitted with the context of the day and similarities and differences with other pieces of writing. Questions about oral text would include knowledge of the position and experience of the participants, as well as the diverse perspectives they could each provide. Choosing the appropriate sources would also include consideration of how the material could be collected, ready for exploration and analysis.

Researcher understanding

The fourth step in the process is the development of researcher understanding. Informed by the methodological principles of possibilities of new understandings, the hermeneutic of actively recreating or reconstructing through investigation is used. This begins as outlined in the first step of the process, by challenging and clarifying pre-understandings, building a platform of an understanding of the context of the period, and raising questions about what sources would be appropriate to the study, their bases, and their perspectives. Then in a careful scholarly way beginning to reconceptualise the ideas based on the material and identified premises of the research. Actively exploring and reconstructing the evidence to seek new understandings and the emergence of patterns and trends, seeing how pieces may or may not fit with the whole. Through investigating, exploring, digging deeper, looking behind, sifting and lifting and interpreting what surfaced, researcher understanding emerges.

Creating the account

The fifth and last step of the process is the research 'product', the outcome of the process, the creation of the account as a whole, "interpreted work communicated through writing" (Koch, 1998, p.1182).

The 'interpreted work' would draw together the process and findings of the research. It would demonstrate the interpretive steps from pre-understanding, through understanding of context and sources, to researcher understanding and the final hermeneutic actively recreating and reconstructing the account.

Application of the framework – methodology in action

The methodology in action in this section outlines how pre-understanding was acquired, the context explored and better understood, and the methods of data collection and analysis of the written and oral sources. Researcher understanding involved the hermeneutic of actively creating and reconstructing the context and sources through a number of contrasting layers until I was confident enough to create an account of the nursing context and the four themes that emerged from the reconstruction and creative interpretation of the rich sources of data.

Pre-understanding

Acquiring some degree of pre-understanding was the first step in the application of the framework.

A lifelong interest in and commitment to nurses and nursing led to the start of this journey. Four decades had seen so much change, so many opportunities and choices, so many 'ups and downs'; nurses and nursing changing in so many ways that the reasons for those changes created in my mind a need to explore them in more depth. In particular I needed to explore the changes in attitudes and beliefs that underpin action related to nursing responsiveness.

It was important to challenge and to build on the pre-understanding that already existed for me as I began the process. I was familiar with the time period, I had been immersed in it, involved in many of the decisions that influenced the direction of nursing education and clinical practice, and I

had ready access to and knowledge of many of the resources that applied to the major changes in the practice and beliefs of the R.N over this time. I could map many of the events of the time, the movers and shakers, the issues of contention, and my own perceptions of what influenced nurses over this time. I needed to acknowledge my position, and to use source material to explore, challenge and question my position. What were my memories and experiences, and how did my attitudes and beliefs influence my own responses over time? What were the memories and experiences of others?

To surface my own memories I used a journal for reflections and ideas. I wrote papers about why I chose the time period, and what I thought the major influencing factors might be, in an attempt to articulate my thoughts and understanding. I then sought contrasting sources and other views of the time.

I needed to identify what some of the predominant attitudes, beliefs and responses were that existed during the 1960s to 1990s, and to consider whether these attitudes, beliefs and responses were common across the profession or whether these developed at different stages or at different paces in individuals. What about New Zealand compared to other countries? How similar were the developments in our nearest neighbour, Australia? What about the differing influences from the United Kingdom, on our practice and from the USA on our education? What would be the most useful sources of information and what should/could I learn from them? To acquire in-depth knowledge of the time I needed to explore the impact of our past on the present and consider possible futures.

Because personal attitudes and beliefs influence individual responses to any given situation, it was important for me to consider what attitudes and beliefs underpinned nurses' actions. I concluded that such an exploration would best be done by interviewing and talking to nurses. Positioning the

context in relation to particular events and issues would enable me to be open to new understandings, different perspectives and to challenge and re-examine my initial attitudes and beliefs. By being aware of my pre-understandings I endeavoured to ensure that they did not unduly influence the findings.

Understanding context

To contextualize the study, I planned to explore - to read widely about New Zealand's past, nursing's past, and the health, education and social context of the period. In order to interpret and understand the events influencing the attitudes, beliefs and responses of the R.N, I needed to be knowledgeable about the context in which these events took place, to recognise interconnections and clarify, challenge and synthesise the fragments to inform my pre-understanding of the topic. To reconstruct as the researcher a perspective of the events that occurred over this time.

Nursing does not exist in a vacuum so an understanding of the context of the nursing environment would assist me to sift the data more effectively in my search for meaning and understanding. The context of the time period, in which nurses lived and worked, included examining the wider New Zealand context as well as the nursing context. What were the key events occurring over the four decades in New Zealand – in our social, economic, and politico-legal context? Were there any special events that might have impacted on nurses and nursing such as the women's movement in the 1970s and the focus on biculturalism in the 1980s? What about the nursing context, what was happening in health education and in nursing practice? It was also important for the bigger picture to consider international influences – similarities and differences.

This step required more reading, reflecting, and discussion. I believed that the impact of the context on the practice and beliefs of the R.N. would be considerable, so I needed to ensure a degree of understanding of the

context of the time period building up to the four decades I was going to study. I used my knowledge of the context of the time period in which nurses lived and worked, to place this alongside the oral and written source material.

I explored what was happening across time through a number of different lenses: the official record and personal comment, the professional perspective and the individual viewpoint – an array of different languages and voices. The major events that influenced or impacted upon nurses and nursing that emerged from the distilling of the context were changes and developments associated with the use of the title ‘nurse’, nursing education, clinical practice, nursing regulation and professional nursing organisations, and are detailed in chapter three – the nursing context.

Understanding sources

The sources used in this study were both oral and written texts and this section outlines **why** they were chosen, and **how** they were obtained. Before choosing specific sources, I decided to immerse myself in the events of the period and read widely to obtain a broad-brush general perspective, the ‘big picture’. From a developing pre-understanding of the topic, and better understanding of the context, I chose four specific sources of material - oral histories, national texts, New Zealand public records, and international texts.

Oral history sources

I chose oral history as a method because it could enable an exploration behind the events of the day in a way that written sources do not. It has a ‘different credibility’ and allows the researcher to understand more about the meaning of events through the personal experiences of those present.

I decided to obtain as the main oral text source, oral histories from a group of nurses who were women of ideas, articulate, informed and aware of the

issues. I also sought participants who could provide particular perspectives of the time because of their involvement in some way with nursing education, clinical practice, nursing administration, nursing history, or nursing politics from the 1960s to the 1990s. This was in keeping with Blumer's guiding principles for oral history mentioned earlier.

The choice of particular nurses as participants was deliberate. The choice needed to encompass nurses of ideas, nurses whose voices could provide a bird's eye view of the world in the absence of any significant written history of the nursing voice.

I was not seeking to generalise from this work, but to reach better or new understandings. As Koch (1998, p.1186) claims, "what matters is gaining rich data which illuminates the question you want answered or explored." I used a number of ways to narrow the field to see who would be appropriate as well as discussions with peers and colleagues in both formal and informal settings to generate sets of names. I then used those that were most congruent with my desire to gain a diversity of perspectives and understandings from a number of different fields of nursing reflecting an interest in planning, policy, and politics.

I finally obtained a group of twelve Registered Nurses whose work and influence spans at least three of the four decades, with some able to provide a perspective over the four decades. Several of the participants were educated in the period prior to the 1960s, began to make an impact in the 1960s, with a major contribution to nursing in the 1970s and 1980s, and this has continued into the 1990s (Margaret Bazley, Jocelyn Keith, Nan Kinross, Anne McDonald, Ann Nightingale and Yvonne Shadbolt). Sally Shaw and Marie Burgess began their careers in the 1960s and their influence spans the 1970s to the present day. The remaining participants began their careers as Registered Nurses in the 1970s and their major

sphere of influence spans the 1980s and 1990s (Mia Carroll, Elizabeth Lee, Lee Mathias, Jocelyn Peach). All of the participants were 'trained' in hospital schools of nursing within New Zealand.

Many of the participants have contributed to nursing across a variety of fields. As examples, Nan Kinross has contributed to the growth of nursing in the fields of administration, education and nursing politics, while Jocelyn Keith has contributed to nursing practice in the community, nursing education and scholarship, and nursing history, particularly in the life and times of Florence Nightingale. Lee Mathias has made major contributions in the area of nursing clinical practice, nursing education, nursing administration and nursing politics. She is now using her knowledge and skills in the wider fields of health care. Jocelyn Peach has contributed to nursing clinical practice, nursing administration and leadership and nursing politics. Sally Shaw has made major contributions to nursing practice in the community, nursing education, nursing and health policy and its implementation and to nursing leadership internationally.

Over the decades many of the participants were active in working to influence the national and international decision-makers of the day, as well as working to increase New Zealand nurses' awareness of the impact of change on nurses, nursing and the health of New Zealanders. In the 1990s all the participants were involved in some significant way with the structural changes brought about by the health, education and social reforms of the late 1980s and the 1990s.

During the time period most of the participants have written papers, given keynote addresses nationally and internationally, assisted in editing important contributions to our nursing history, for example editing *A Profession in Transition* (a selection from the writings of Beatrice Salmon – a New Zealand nurse academic) and contributing and editing *Objects*

and outcomes NZNA, 1909 – 1983. Marie Burgess has published a New Zealand nursing history text, *Nursing in New Zealand society* and *A guide to the law for nurses and midwives*. Many of the participants have also been active on government appointed committees, and the executive or committees of NZNA and/or the Nursing Council of New Zealand (hereafter called the Nursing Council).

My own experience includes contributions to nursing education, nursing politics nationally, internationally and to nursing leadership. I have also contributed to several government appointed committees. The Nursing Education Review and Advisory committee (NERAC), National Action Group (NAG), Trade Union Education Authority (TUEA), the New Zealand Qualifications Authority (NZQA). In addition I have worked with NZNA national committees, written many papers, given keynote addresses nationally and internationally, represented New Zealand at a number of international meetings, and contributed to international policy and nursing leadership as part of ICN.

The participants in this thesis have clearly been part of both the nursing and the wider New Zealand context of nurses' experience. They are 'women of ideas, articulate, informed and aware of the issues' and have been able to provide a variety of perspectives over the period and to assist, interpret and give meaning to events from their own past, their own present and to comment on what actually happened to their own dreams for the future.

By including nursing oral histories as a source of material, first hand perspectives of the prevailing attitudes, beliefs and responses of nurses can be recorded, sifted, and reconstructed. In addition, through my own personal participation in nursing affairs, with and alongside nurses over this period, I add another perspective and awareness of some of the gaps in our written-recorded history. Data about nurses' attitudes and beliefs is

certainly not easily accessible and some of my material will be 'added' to the NERF oral history archives to provide another accessible source of data.

The question of how an oral history interview differs from narrative and storytelling was an interesting one for me to consider when deciding on methodology. Opinions vary about "what a telling must consist of to be labelled as narrative". Sandelowski (1991), an American nurse researcher, in addressing this question claims that

generally, narratives are understood as stories that include a temporal ordering of events and an effort to make something out of those events: to render, or to signify, the experiences of persons-in-flux in a personally and culturally coherent, plausible manner.

(Sandelowski, 1991, p.161)

Within the oral histories there were wonderful stories, images, and examples that highlighted or gave a point meaning, which I would describe as storytelling.

There are, however, problems in the storytelling. Literal transcriptions of oral histories are often full of 'ums' and fumbles and pauses and blanks. In the interpretation the stories are often given "cohesion, meaning and direction; they are made to flow and are given a sense of linearity and even inevitability" (Sandelowski, 1991, p.163). In the reconstruction of oral histories we are able to understand the experiences of the participants as a story, a representation of events, feelings, thoughts and meanings as known to them.

Understanding more about the selected oral history participants involved several steps, as all human beings come with a story, and a history. One step involved thinking about where they were located in nursing, in time and in influence. Some of the considerations included my thinking about

their background generally and in nursing in particular. Where did they fit in the time period, and what was their major area of contribution? For example, were they primarily academics, practitioners, or involved in policy development and/or implementation? Prior to the first interview where were they placed in relation to other participants, what might they contribute that would be the same – an echo of other participant contributions, or what might they choose to emphasise that would be different? How would my grasp of the period differ from theirs? Were they informed sophisticated ‘knowers’ at the time they were describing, or naive participants at the beginning of their nursing journey? Another step was post interview reflection. Why did participants say what they said, what stories did they have to tell that enabled new insights and meanings to surface? How did their attitudes, beliefs and responses change over time? What might have influenced the changes for participants with regard to the period and their nursing careers over time?

The oral histories – data collection process

The reconstruction associated with the oral histories in this thesis is the result of the process of gathering the data, and using the framework and process to interpret the lived experience of the nurse participants.

Any study by a graduate student involving humans in New Zealand requires ethical approval from the Human Ethics Committee of the educational institution concerned, in this case the Victoria University of Wellington Human Ethics Committee. Where the people concerned are in the health area, ethical approval is also required from the appropriate health agency (The Central Regional Health Authority in this instance). Both organisations provided very clear guidelines outlining their requirements; and ethical approval was obtained without needing any change to the proposal submitted. (Copy available on file, Department of Nursing and Midwifery, Victoria University of Wellington).

The participants were approached in writing seeking their agreement to participate in the study along with details required by the Ethics Committees of the Victoria University of Wellington, and the Central Regional Health Authority.

Apart from requiring an outline of the objectives, overall design, benefits and value of the research, I was required by both ethical committees to provide information about the characteristics of the participants, how informed consent was to be obtained, how confidentiality was to be protected and briefing and feedback procedures.

Informed consent was obtained by writing a letter to the participants seeking their willingness to participate in the project and their consent to the conduct of oral history interviews (Appendix Two). A participant consent form was enclosed detailing the purpose and conduct of the research. All but one of the participants approached by letter agreed to participate. I did not hear back from this participant. One prospective participant contacted by telephone did not agree to be taped as she had had an unfortunate oral history experience in the past, but she did discuss issues over the telephone and agreed to comment on any material sent to her in writing.

Confidentiality in relation to material was addressed by making it quite clear that any information obtained from the participants of a confidential nature would not be disclosed or made public without the participant's express permission and approval. Any reference to third parties that was not already available in the public domain would not be disclosed without express permission from the third party concerned. The matter of identification of the participants was also an issue to be resolved. All participants agreed that I could use their full name in the thesis. Any material attributed directly to them could also be used as long as I sent the information to the participants for approval before final printing. I believe

that being able to identify the participants adds a particular perspective to the opinions they expressed.

Following guidelines for oral history collection (Fyfe & Mason, 1995), I conducted the oral history interviews with the participants either in their home or workplace (eight), in the home of the interviewer (three), or at another venue convenient to both parties (one). The venue was the choice of the participant and I made every effort to ensure the minimum of inconvenience to the participants. I arranged the setting to suit them, and brought all the necessary equipment including extension leads. I acknowledged that prior interaction between the parties could be a possible focus of bias. I knew some of the participants primarily in a professional work life situation while others were also known socially. To lessen the likelihood of bias I made a particular effort to ensure that the interview process was as similar as possible with all participants receiving the same information in writing prior to the interview, and being asked the same trigger questions. Appointments were made for the interviews with a clear time frame established, and the interview was taped.

The interviews followed a simple structured approach and took between one and a half and two hours each. The participants were asked to provide some background regarding their nursing careers and then to outline their perceptions of the changes in the practice and beliefs of the Registered Nurse and the factors influencing those changes over the four decades since 1960. In order to ensure a common approach to the flow of ideas from the participants, I had decided to let conversation flow as much as possible, and very few probing questions were asked or prompts provided.

A Sony Stereo cassette-recorder WM-D6C with a separate Sony microphone ECM F9 was used to record the data. This quality equipment had been purchased through a research grant from the Nursing Education and Research Foundation (NERF) on advice from the Alexander Turnbull

Library oral history department. The quality of the tapes in a quiet environment was excellent, but where there were uncontrollable external noises some interference came through as well. I also took some notes during the taping sessions of points that I thought were significant.

At the commencement of the data collection, three methods of data storage were planned. Files in date order containing the raw data; pen or computer summaries of the data; and a personal log recording how my time was spent as well as any changing impressions or concerns. The participant summaries were filed in named files easily identified. The log was replaced over time by a notebook and tapes of interviews with my primary supervisor and became an important focus for directing my thinking and exploration as I sought to interpret understand and clarify the meaning of the data.

The participants' tapes were preserved without editing, noting the time, place and circumstances of the interview, and a master copy was obtained for archival purposes where permission had been given. The tapes were stored at my home and after a discussion at a research school I established clear arrangements regarding disposal of the tapes should anything happen that would prevent my completion of the study.

Plummer (1983) describes some of the dimensions of possible bias in an interview setting. To reduce misunderstandings on my part, I used his 'checklist' as a guide. To minimise respondent bias, issues to be addressed included the possibility of inaccuracy, gaps in knowledge and content 'taken for granted' and therefore not revealed. To manage this I developed a strategy that where there was any doubt expressed or possible conflicting data, I was able to seek collaborative data or confirmation from other sources. Doubt or conflicting data mostly seemed to be associated with time, and I was able to verify information from other participants' interviews, written sources and my timeline data and from

participants' CV's. When reflecting on memories of some 30 years ago, it was clear that for some of the participants detail had been forgotten. I sought to fill the gaps from other sources and did not use incomplete data.

To minimise researcher bias I was aware that my own attitudes, beliefs, and assumptions could shape the outcome. Peirce (1878), a mathematician, physicist and philosopher, in a classic article titled '*How to make our ideas clear*' states that belief is a pause or resting-place. No closure is final because who can be sure of what we shall not know in a few hundred years? I was very clear about my current beliefs, and very aware that the possibility of new understandings could shape and change my beliefs as illustrated later in this study.

I believe that my involvement in nursing over the period under study was an advantage to the pre-understanding of the attitudes, beliefs and responses articulated by the participants. I also acknowledged that while there are so many helpful implicit understandings in one nurse discussing issues with another nurse, there may also be implicit misunderstandings that an experienced interviewer might pick up and clarify. An interviewer without knowledge of nurses and nursing might also identify gaps, gaps in the 'taken for grantedness' that a nurse interviewer might miss.

Being involved in the era under study, knowing the participants, having ready access to material through my own knowledge of the system meant that I needed to be especially aware of the possible implicit meaning, understanding and interpretation I might give to the data that the sources did not really support.

Material for the oral history interviews was available to listen to over and over again to ensure that the words were correctly quoted, the concepts described were in the correct context, and to develop my own interpretation of the new meanings and understandings gained.

In acknowledging that meaning is contextual, I was also aware of the contextual nature of my own perspective. While some practitioners of oral history have shown a great deal of ambivalence about the need for an informed interviewer, Lummis (1987) believes that such knowledge is an advantage

Knowledge of any area of experience about which one is interviewing can be a tremendous advantage in ensuring that the conversation is pursued intelligently, and in knowing where to question and deepen a participant's account.

(Lummis 1987, p.22)

Godden, Curry, and Delacour (1992) discuss some of the problems of 'insider history', Where an examination of the contexts may reveal assumptions that to the insider appear to be common sense or obvious, whereas the outsider might want the point explained. They suggest that "it is exploration and questioning of the 'obvious' in history that often provides the richest sources of explanation and understanding" (Godden et al, 1992, p.28). I certainly found it necessary to be very aware of how easy it was to slip into an 'insider' view of things and to continuously work towards objectivity and clarification.

In applying this comment to nursing, interpretation of the potential for new understandings is particularly applicable to the oral history participants in this study. The participants start from their own self-knowledge and pre-understanding of what it is to be a nurse. They begin with their 'training' and life as a student nurse, the opportunities that followed graduation, nationally and possibly internationally, and the career patterns that developed. They can outline their experiences from the present perspective, looking back at the past going through and across time, and also reflecting on how they have changed. They can also look forward from the past – what they had worked for, and whether their

vision had become a reality. They then develop a deeper awareness of where they stand and can begin a further exploration of understanding the nursing world. The past, present, and future focus lends itself very well to such an interpretation of events and the use of oral histories as an important source.

Methodologically, however, tensions exist with the concept of an 'insider' view. I worked hard to take into account the need to distinguish between the 'insider' view each participant had and used to understand their world and the 'outsider' view shaped by who they were and what they experienced.

It was clear that the oral history material obtained from these twelve nurses would provide a wide and diverse view of the nursing world over the four decades, and enable me to contrast national and international trends, as well as exploring events through different eyes. They were able to share their experiences from their student days through to their days as nurse leaders in their field, exploring the past, the present, and speculating about the future.

While oral histories associated with attitudes and beliefs can provide a perspective that is different from that obtained from written sources, it was also important to consider the contextual information provided by the written texts.

Written sources

There were multiple voices that needed to be heard, and a variety of written texts were sought in order to introduce some rigour to the research question. There is a rich resource of material available in international and national textbooks, journals, and a variety of public records, especially reports and reviews relating to the major changes in nursing education and clinical practice over the four decades. I had access to many libraries

primarily at the New Zealand Nurses Organisation (NZNO), Victoria University of Wellington, The National Library and the Alexander Turnbull Library in Wellington, the University of Auckland, and the nursing library at the Auckland Institute of Technology.

The national texts were predominantly journals particularly the NZNO Journal *Kai Tiaki Nursing New Zealand*. Newspapers included *The New Zealand Herald* and *The Dominion*, and magazines such as *The Listener*, *Metro*, and *North and South*. Newsletters and policy documents from a variety of sources such as NZNO, the Ministry of Health, the Nursing Council, the National Council of Women, and political parties added to the New Zealand data. New Zealand Nurses Association (NZNA) archives at the Alexander Turnbull Library were accessed as well as the archives held at the NZNO national office. Three nursing indexes were also used. *From Candles to Computers* (Sargison, 1986), the major annotated index of the history of nursing in New Zealand, the *NZNJ (Kai Tiaki)* indexes established in 1908, and the *Index of New Zealand Nursing Research* published by the National Nursing Research Section Committee of NZNO (1997).

Public records included the Government Department/Ministry reports in the *Appendices to the Journals of the House of Representatives*, *The New Zealand Parliamentary Debates*, and letters and files in the Alexander Turnbull Library, Wellington.

It was interesting to note that while reading and searching many of the available New Zealand written sources, they outlined events that occurred and responses to change (Annual reports of NZNA and the Nursing Council, the Department of Health, 1985, 1988), but there is little recorded that really explored the attitudes, beliefs or the responses behind these events. Do we really know how nurses felt about key events? Does the official formal record match the unofficial informal record if such a

record exists? Discrepancy would seem to be quite common according to Chinn (1990). In New Zealand there is some support for this in the more contemporary work of Stevenson (1997), who explored the realities of general hospital nursing in New Zealand 1945 – 1960. She suggested that the informal, private stories of the New Zealand R.N certainly conflicted with the official record.

Additional written texts included papers from my personal work on a variety of committees. These included nursing curricula from several polytechnics, minutes and background papers from my work on the executive of the New Zealand Council of Trade Unions, the Board of the New Zealand Qualifications Authority, and the Council of the Open Polytechnic of New Zealand.

With this background range of material I was ready to compare and contrast some of the ideas in the national and international texts. The international texts included general health and education texts as well as nursing textbooks written during the period, providing a feel for trends and patterns. For example, it was not until the 1970s that the concept of ‘accountability’ came to be widely used in the literature. In the 1970s and 1980s, tertiary education was clearly further developed in North America than in the United Kingdom, Australia or New Zealand, and curriculum details and philosophies of teaching and learning were in the nursing journals. Details of changing modes of practice were clearly coming from the experience of nurses in the USA in the 1970s and 1980s. New Zealand was well advanced in the 1980s regarding health and economic restructuring and chapters about the New Zealand experience began to appear in international texts. International journals highlighted emerging trends before the textbooks surfaced, for example, trends in evidence-based practice and critical thinking. International policy documents were readily available to me through ICN, ILO, and WHO. Through formal relationships between ICN and the other two international agencies, I

received in a monthly mailing from ICN key documents relevant to health and nursing. These would include all press releases and position statements from ICN, Technical Report Series documents from the ILO, and reports of the annual World Health Assembly and relevant advisory groups such as the Global Advisory Group on Nursing.

The written sources – data collection process

As I read the international and national texts I took notes of key events and concepts. I photocopied pages that explored new ideas and began to create files under various topics. I mapped key events under contextual headings along a timeline (for example, broad headings like nursing education, nursing practice, keynote speeches, and visitors to New Zealand). I also mapped data from the written records according to themes (health restructuring, nurse leaders of the day, modes of nursing practice, nursing educational developments). I developed a framework in which I could locate any central themes that emerged.

This enabled me to build up a visual picture of the period and note such things as the changing role of women and greater understanding of biculturalism. Noting movement from a period of relative economic stability, full employment, and a high standard of living, to major societal change and instability in areas such as employment and economic management. Noting development of liberal trends after years of resentment of Government restrictions and regulations, ‘causes’ such as peace, social conscience and antiracism as liberal trends of the left, while to the right, liberalisation of the free deregulated market on the international tide and the spread of global ideas.

Scanning key written sources such as New Zealand nursing journals, I used the libraries to find original copies of the journals. The most valuable journal source was the monthly NZNO journal currently titled *Kai Tiaki: Nursing New Zealand*. I read the bound copies of each journal from 1960

until December 1999 searching each individual page, as the index does not necessarily indicate the treasures within. Contextual maps along a timeline were developed from these sources and were immensely valuable in either validating the information from the oral histories, or providing another perspective.

To build up a picture of how the government of the day was involved in, or concerned about, nursing affairs I studied *The New Zealand Parliamentary Debates* from 1960 until 1997. I used the index for any reference to nursing or health and cross-indexed references then scanned each page. Most of the references were linked to nursing shortages, student attrition, nursing education, and the closure of hospitals.

Government Departmental or Ministry Reports in the Appendices to the Journals of the House of Representatives from 1960 – 1997 were also read and notes taken of references to nursing that helped build up a picture of the key concerns of the day. This was a fascinating exercise, with early comments being quite specific both geographically, and with reference to particular groups of nurses such as the public health nurse. There was also reference to the important contribution to the health of the peoples of New Zealand made by those mature women who returned to the nursing workforce during times of acute nursing shortage. Later references became more general until in 1988 after the passage of the State Sector Act and the subsequent focus on ‘outcomes’, there was no mention of the health workforce at all. It was as if the health and education of the nation happened without people. It is of concern to me to note this trend as the early reports were a rich source of past events and that personal information now appears to be lost from the official record.

On occasion it was interesting to contrast some of the sources. For example *The New Zealand Parliamentary Debates* offered a very broad-brush approach in the main except in the 1960s and 1970s when education

was an issue and the debates seemed quite fiery. The government annual reports to Parliament became less and less personal with fewer and fewer references to the workforce. (While the 1961 report expressed gratitude to the nurses of the country the reports from 1987 on did not mention the workforce). *Kai Tiaki: Nursing New Zealand* remained a constant source of individual nurses' stories, highlighting opinion, punchy editorials and presidential addresses and constant reference to current concerns.

I gained a deeper understanding of the authors and their purposes at the time of writing by considering the audience for whom the author was writing. For example an annual report is written to record key events chosen from the perspective of the writer; the ICN's President keynote address is written to inspire, enrol, cajole; an academic paper is written to explore and debate; oral history is told from personal recall of events and feelings, sometimes about events that took place many years ago; and an historical paper is written to interpret and reconstruct the past.

Commentary on analysis of source material

The source material gathered from the diverse oral and written texts provided a wealth of data ready for analysis. Methodologically there are tensions between the different perspectives of the oral and written sources. The context of the oral sources can be more easily established, as it is possible to clarify what the participants were doing at the time and what their perspective might be. In reading their conference and workshop papers and assignments or position papers in some instances it was also possible to ascertain why they said what they did in particular contexts, and why they spoke passionately about an issue or put a particular perspective. This was not always possible with written texts when the author was not well known to me or in the public records where the purpose of the record was simply to record the facts.

In examining the past, Hockett (1955) an American historian, reminds us that statements are raw materials that must not be mistaken for facts. They may be facts, but we cannot take this for granted. In assessing 'factual' data from the participants I sought at least one other source. Of course the opinions and individual experiences of the participants were subjective and were not able to be verified other than when the participants repeated the story in the second interview. Similarities and differences were noted and the tensions that existed when participants were speaking from different perspectives about the same event. For example Nan Kinross working in the Health Department, Anne McDonald in the Nursing Council and Yvonne Shadbolt as an educator in a hospital school of nursing all had different perspectives about the attitudes, beliefs and responses associated with the transfer of nursing education.

The oral history material analysis began with transcribing the tapes. As soon as possible following the first interview (sometimes the same day – greatest delay two weeks), I coded the content of the tapes using a similar format each time. This was to enable me to look for patterns and themes using a separate sheet of paper for each of the following headings. Key points in the participants' career; changes in the practice and beliefs of the nurse; possible influencing factors in the decades 1960, 1970, 1980, 1990; socio-political issues; policy issues; legislative issues; miscellaneous issues; and any follow-up required.

These summaries were entered into the computer and copies of the transcripts were sent to the participants including a stamped addressed envelope, asking them to read the material and to comment on the accuracy, as they perceived it. They were also asked to add any additional information that occurred to them as they read the transcript, and to return the information to me. All the participants returned the transcripts with varying degrees of comment, which were most helpful.

I also sought approval at that time for inclusion of the first interview tapes in the Nursing Education and Research Foundation Oral History project held in the Alexander Turnbull Library in Wellington. Ten of the participants agreed to this, two with provisional requirements. One requested that two-third party names be deleted from the tapes prior to lodging them with archives, with the other participant requesting a 25-year embargo before the tape was made publicly available.

In utilising written texts as sources, it was important to seek verification of data. Christy (1975) warns that we tend to believe anything in print, especially if it is found on an old document. In my experience it is likely that uncritical readers believe anything in print, period. The material doesn't have to be old – just in print. Christy (1975) when commenting that facts are rarely easy to establish in researching the past suggests a test of verification relating to whether data could be described as factual, probable, or possible. That to be fact, two independent primary sources corroborate the data; to be probable one primary source and no substantial contrary evidence passes the test of critical evaluation; to be possible, corroboration of two or more secondary sources are needed.

With regard to data from the written record I sought at least two independent primary sources to corroborate the information. Authenticity of documents was not a major issue as most of the public records were primary sources. However, I sought to ensure that I was aware of where, when, why and by whom the records were written. Wherever possible I sought to find original documents, aware of the fact that the further the words travel from the originator the more distortions are likely to occur. I also made efforts to find original articles rather than quotes within an article.

Davis, Back, and MacLean (1977, p.5) emphasise the fact that while all primary sources are subject to factual error, in writing about oral history

“anyone who uncritically accepts an oral history memoir as historical truth is destined to misunderstand the past”. The reliability of information was particularly important and I was aware of the need to avoid reading into statements a meaning other than that intended.

There is a great temptation to make this mistake when one wishes or hopes to find a particular meaning in a statement and great care is required to avoid this form of intellectual dishonesty. Taking words out of context is a common form of transgression.

(Hockett, 1955, p. 41)

This was important for me when using quotes from the participants and I sought to avoid this form of transgression by sending the material back to the participants for checking prior to final submission of the thesis. No quotations attributed to the participants were used without the participants’ permission.

Putting the oral and written source material together I used several approaches to interpret and begin to understand the meaning(s) of the data I had collected from so many sources. I had timelines and contextual maps from the written records, key articles full of the rich ideas of from our past, and the coded records from the participants’ tapes. I felt that meaning and understanding would most likely come from the tapes so I listened to them several times with a view to seeing how the participants linked their comments or what they emphasised. I also began mapping timelines of the events they discussed, and following the flow of their story seeking key impressions. I worked on mindmapping concepts but kept coming back to the same headings I had used initially with the participant’s material.

Once I had reached this stage in the process I was confident that I understood the sources and their contents, for example the similarities and differences between the individual participants, the contrasts in and

between the decades, and between the national and international texts. I felt confident that I had a sufficient grasp of the context and the issues to move towards researcher understanding that involved working actively to interpret the material.

Researcher understanding

Sifting through the data and interpreting the findings to enhance my understanding is part of the fourth step in the framework. It was built on the platform of my pre-understanding of the time period in relation to the research question.

It also built on my understanding of the nursing context, sources of data, and analysis of the findings. Researcher understanding involved the hermeneutic of actively recreating and reconstructing the material prior to producing an account, the research product, exploring the research question - how can we learn from the beliefs and practice of nurses in the past to create a positive effective future?

The diversity of sources provided different perspectives, different points of understanding. After thinking, reading, reflecting, mindmapping, and discussing my ideas with others, the field narrowed to consideration of the contextual landmarks under the headings of the socio-political context, policy decisions and key legislation. Several questions emerged to guide the analysis. What factors from the socio-political context may have influenced the practice and beliefs of the R.N. in New Zealand since the 1960s? How influential were policy decisions at national and regional and local levels (including local health, nursing and education policy, as well as the policies of national governments? How much say did the nursing profession have in either the policy decisions or their implementation?

Policy decisions have often led to major legislative change. Key legislation that has had an impact on nursing needs to be examined to see

what the impetus was for the legislation, and the effects of its implementation. Was the impetus partly generated by nurses? (Such as the Nurses Act 1977). Was the legislation generated as part of a wider policy direction? (For example the State Sector Act 1988), or was the legislation generated as part of a social trend? (Like the Consumer and Privacy legislation in 1994). As there were many pieces of legislation that affected nurses and nursing over this period, the question was how did the introduction of key legislation impact on the attitudes, beliefs and responses of the Registered Nurse in New Zealand?

In addition to the socio-political context, policy decisions, and key legislation, there arose a question about nurses themselves. Were they a major factor influencing change? How did nurses respond to the many changes over these four decades?

It became increasingly clear to me that it was primarily nurses who influenced progress within the nursing context – a feature that became increasingly significant to this thesis. While the written sources hinted at the nurse's influence, it was the voice of the oral history participants that revealed the extent to which attitudes and beliefs were reflected in the actions taken.

Gradually the evidence surfaced around the significant influence of the nurse and the primacy of the nurse began to emerge. Issues that I had expected would be in the 'foreground' of the data had become the 'background'. The impact of external factors such as legislation, government policies, socio-political factors, while major challenges, were not the major issues and influencing factors to emerge.

What stood out now was the primacy of the nurse, the powerful influence of the nurse. While the context was certainly important, it was nurses who made the decisions, nurses who developed the ideas and nurses who were responsible for the changes in their own attitudes, beliefs, and responses.

Exploring these ideas enabled me to shift focus from key events, to key responses of people (nurses), particularly what nurses thought and how their ideas changed and influenced their responsiveness.

It was at this stage in the process, with the primacy of the nurse in my mind, that I explored the material again, actively reconstructing the context, with a focus on the specific influence of the nurse, both as an individual and as part of the profession. This exploration included some ideas and questions associated with contrasts. Were nurses in New Zealand the same or different with regard to developments and trends in nursing internationally. Were the stories the participants chose to reveal stories about individuals, the profession, or both? What were those changing trends in nurses' attitudes, beliefs and responses within or between the decades? Were the changes all big picture changes, overarching themes, or was there evidence available to explain more clearly the intricate details of the responses?

Thinking through these questions, exploring them and relooking at the data, ideas emerged from this deeper layer of analysis, revealing the significance of the background of the nursing context and four themes demonstrating forward movement and nurses making a difference. Each section, context and themes, contributed to the overarching concept – the primacy of the nurse.

The context focus was on issues and factors relevant to nursing. The first three themes were: 'Nurses' decision-making: changes over time'; 'an emerging understanding of autonomy and accountability'; and 'nurses as a driving force'. A fourth theme, 'creating a nursing future', was informed by and built on the previous themes. This development took place over several months.

I realised that I needed to gather more data that specifically related to the themes. I contacted each of the participants, seeking a further oral history

interview. Nine of the participants agreed and the richness of the data obtained from the second round of oral history interviews has been an important contribution to this thesis. These interviews strengthened the material around the primacy of the nurse and the emerging themes.

With the emergence of the four themes the focus of my understanding changed. As I sifted through sources of data, I was constantly understanding ‘differently’, applying the methodological principles and using the hermeneutic of actively recreating ideas from the material.

The four major sources used in this thesis to inform the context and themes were oral history material from the participants, national texts, international texts, and New Zealand public records. (See Figure One.)

Figure One: Four sources used to inform the context and themes.

The four series of contrasts (see figure two) used included contrasting the big picture – the broad brush over the decades - with the little picture, the precise detail of events and change. Contrasting the attitudes, beliefs and responses of the profession as a whole, with those of the individual nurse, how and why did they differ? Were there differences up and down the country? Contrasting what was happening in New Zealand with what was happening internationally – Were we behind overseas trends or were we in front? Why were we different or why were we the same?

Figure Two: Four contrasts used to inform the context and themes.

Each of the four sources was explored in turn through each of the four contrasts looking for similarities and differences, and confirming or refuting points of view. For example when different modes of clinical practice were mentioned in the texts and oral history interviews, I explored the changes in and between the decades, and how clinical

practice had moved from task to patient orientation. The major 'big picture' trends within the profession as a whole were identified, alongside the 'little picture' details as expressed by individual nurses orally or in writing, outlining their stories and their struggles with these changes. Differences between the practice of individual nurses and the approach of the profession as a whole expressed through policies and published texts were also considered. How the nursing schools were teaching patient assessment and problem solving before the profession as a whole was ready to commit these ideas in clinical practice throughout the country. The contrasts between national and international trends were the final sift, showing New Zealand following international modes of practice trends.

The last step of the process clarifies how I synthesised the material and prepares the reader for the account that follows.

Creating the account – the process

The challenge in the creation of the account was how to take the substantive understandings that had emerged during the exploration of the data and present the findings in such a way that the reader would grasp the significance of the primacy of the nurse during this period.

Returning to the premises described in chapter one, this account proposes that we can learn from the past, that the voice of nurses themselves are capable of revealing something about the link between attitudes, beliefs and responses. How the attitudes and beliefs of the New Zealand R.N influenced their responsiveness. It is also proposed that nurses and nursing only move forward with the specific influence and contribution of nurses themselves.

I have explored and clarified the importance of this link between attitudes, beliefs, and behavioural responses in this study. Mingay (1993, p. 21), a UK nurse educator, states that "to take but a cursory glance at the

historical perspectives of nursing one has to be impressed by the power of the transmission of values, attitudes and beliefs passed on so religiously from one generation to another”. Attitudes and beliefs are learned and are frequently transmitted as part of our socialisation. Mingay (1993, p. 23) also suggests that while much of the literature focuses on the attitudes of the individual, attitudes can also be shared and transmitted within a reference group – in this case the profession of nursing.

This relationship is supported by my study, and therefore throughout the written account I have explored attitudes, beliefs and their link to the responses of both the individual nurse and the profession as a whole, as they reveal the primacy of the nurse.

Using the methodological principles outlined earlier in this chapter and the first four steps of the framework, adapted from Droysen’s steps of interpretation, the significance of the background of the nursing context and the four themes were revealed.

The nursing context chapter included the background of the period of the study and a platform for the four theme chapters was created. The participants’ voices alongside the material from the written texts start to reveal evidence of the importance of the influence of the nurse during the 1960s – 1990s.

Meanings and interpretation of the material from the oral histories, supported, or argued against, by data from the written sources was explored in the theme chapters. The exploration focused on an interpretation of the content, and expanding where appropriate on the contextual influences. The effects of decision-making ability, the emerging understanding of autonomy and accountability, and the impact of nurses as drivers were explored as well as the changes in nurses’ attitudes, beliefs and responses over time.

Earlier in this chapter I referred to the important influence of a book edited by Porter and McDonald (1996). It was in the introduction to the text *My hand will write what my heart dictates* (Porter & McDonald, 1996) that I found the idea for the metaphor of a quilt. I was reading about how various writers and researchers put their work together in a coherent fashion. Porter and McDonald described their approach as resembling working with “a capacious patchwork quilt – a large object made up of many small pieces arranged and stitched together to create a few larger patterns or themes” (Porter & Macdonald, 1996, p. 2).

This approach resonated with me as I too had many small pieces of information that could be arranged to create larger patterns or themes. Porter & Macdonald wrote of shaping and creating a narrative out of the material, and the need to recognise that the reader imposes a context and therefore a meaning from their own perceptions and understandings. They presented their material by choosing an overarching theme and several sub themes which were then illustrated by examples of the women’s writing.

In the early part of my analysis, once I had found the themes, I was struck by the ‘rule of four’. Substantively I had four themes. ‘Nurses’ decision-making: changes over time’; ‘an emerging understanding of autonomy and accountability’; ‘nurses as a driving force’; and ‘creating a nursing future’. Each theme had four content areas. The techniques used to reveal the themes utilised a series of sources and contrasts. Ironically I had used four material sources (oral history interviews, national texts, New Zealand public sources, and international texts). The interpretive strategy used to sift each of the four sources was derived from processes which used four contrasting ideas (time in and between four decades, big picture/little picture examples, individual/professional perspectives, and national/international trends).

I looked at this pattern and wondered what the significance of the pattern of four might be. It seemed to work well, to be right for the material that had emerged, and to suit the idea of creating a quilt. Utilising the idea of a pattern of a series of four, I decided that my quilt should be constructed as a 'quadtivity' quilt. A quilt built up by a series of patterns of four (hence the prefix 'quad') and is an act of creativity (hence the suffix 'tivity').

The metaphor of the quilt

Some people are content with what the tapestry shows on its face – the aesthetic power of its designs and images, its colours and textures. But other people need to turn the tapestry around to see how it was put together, even if that means examining a tangle of threads. To understand the tapestry more fully, one has to look at both the front and the back to discern the relationship between the images displayed on the front, and the conditions of their production evident on the back.

Lipsitz (1992, p.106)

The power of this metaphor enabled me to imagine how I might create the account in a way that would be easily understood. The quilt pattern is a very appropriate vehicle as it could demonstrate the building-up of the themes and patterns that emerged from the source material. The underpinning of the framework and the interpretive processes used clearly enabled the themes to surface. The relationship of the themes to each other and the revelation of the primacy of the nurse can be clearly demonstrated by the quilt metaphor.

Like the Lipsitz reference to a tapestry, the next section describes what the quilt shows on its face as well as the relationship between the images on the surface, the four themes, and how they were produced as evident in the layers and relationships found beneath the surface.

On the surface of the quilt are four substantive sections of the quilt, the four themes. These very clearly sit as squares on the face of the quilt. Each square provides the structure for the elaboration of a further four sections representing the content areas of each theme. These four substantive sections of the quilt, the images on the surface, sit on top of the layer they have revealed, the primacy of the nurse.

Looking beneath the four substantive sections of the quilt and the primacy of the nurse, the background can be revealed. It is then possible to see the relationship between the layers that supported the themes and enabled them to emerge. The framework, the nursing context, the source material and contrasts used to sift and lift out the four themes, and the content areas that revealed the primacy of the nurse.

The four-sided square quilt is built up from a base layer of the underlying framework based on the concepts of understanding through interpretation identified by Droysen, and the process of analysis. The context layer is placed on top of the base layer as it enables understanding of each of the themes. The surface layer of the primacy of the nurse sits on top of the context layer and is made explicit by the four squares illustrating the theme chapters. (See Figure Three.)

Figure Three. The overall pattern of the ‘quactivity’ quilt.

The quilt metaphor provided me with a clear picture of how to use the 'many small pieces' of data and how to arrange them to create the whole. I had considered other possible metaphors to reveal the themes, but was eventually satisfied that the square quilt metaphor was best suited to the creation of the whole. This enabled me to set out 'methodology in action' and write the five chapters describing the nursing context and the four themes.

Considering how to write about and present the nursing context chapter, I made a decision to write a descriptive account of the major events of the period. Evidence that identifies the importance of nurses, individually and the profession as a whole begins to surface. Nurses making a difference. The impacts of external factors, while major challenges, are clearly identified as less important to our future than the responsiveness of the nurse. The context layer informs the four themes and using the interpretive framework begins to surface the overarching concept of the primacy of the nurse which is further developed in each of the four theme chapters. I decided that the context should be seen as both underpinning and informing the themes and written about separately to avoid distracting the reader from the voices of the nurse which could happen if included within the theme chapters.

As I thought about each theme, I imagined how each square might look, how by naming the four content areas within each theme, I could show the relationship between each of the content areas. Each theme provided me with content that had been sifted through four contrasts enabling me to surface the attitudes, beliefs, and responses revealed within each theme.

This enabled me to recognise and make explicit similarities and differences. This related to changes over four decades, illustrating how it is possible to identify trends and patterns. These trends and patterns needed to be considered using big picture/little picture examples. Were

the trends national or local? Were they mainly broad and general, or specific and detailed? Each finding also needed to be considered in relation to the effect on the individual or the profession as a whole. Who made the difference? Was it an individual nurse, a small group, or the profession as a whole? What was the role of the individual nurse? Were there specific individuals who led the way? Did the profession lead or follow a trend?

The last exploration for the content of each theme was consideration of national developments compared with international trends and patterns. Thinking about how this careful exploration could be clearly represented, the following figures (Figures Four – Seven) enabled me to put the pieces together and demonstrate each square on the surface of the quilt. Each of the themes is interrelated and builds on each other, and the quilt would not be ‘whole’ without each piece. The square associated with each chapter is replicated at the beginning of each chapter to show the placement on the quilt.

The first theme: **Nurses’ decision-making: changes over time**, is square one of the quilt, and is described in chapter four. The four areas of content that emerged relevant to this theme were: the influence of the environment in which decision-making occurred; the changing patterns of the decision-making process over time; the changing attitudes and beliefs related to decision-making of individual nurses and the profession as a whole; and the decision-making responses made by individuals and the profession. (See Figure Four.)

Figure Four: Square One on the quilt surface – Nurses' decision-making: changes over time.

The second theme: **An emerging sense of autonomy and accountability**, is square two of the quilt and is described in chapter five. The ability to make decisions relating to clinical practice led into the question of autonomy for the nurse, with issues of autonomy and accountability becoming increasingly important over the decades. The four areas of content that emerged relevant to this theme were: the need for an exploration of terms (autonomy, accountability, authority, and

responsibility); the importance of the emergence of different understandings of these terms over time; the changing attitudes and beliefs of individual nurses and the profession as a whole; and the responses made by individuals and the profession. (See Figure Five.)

Figure Five: Square two on the quilt surface – an emerging sense of autonomy and accountability.

Once nurses are confident in their ability to make decisions, and are willing to accept the authority to do so, then the possibility of developing an understanding of autonomy and accountability becomes a reality.

The third theme: **Nurses as a driving force** is square three of the quilt, and is described in chapter six. The concept of nurses with a clear direction and purpose and who enrol and enthuse others to see value in moving forward, is built on effective decision-making and an emerging understanding of autonomy and accountability. In the third theme chapter the major finding of the research – the primacy of the nurse - is revealed. Early analysis of the oral and written sources had hinted at the increasing importance of the influence of the nurse but until the themes emerged, it was not really dominant.

The four content areas key to the primacy of the nurse were revealed. They were: the idea of nurses taking charge, nurses in charge of their attitudes, their values, and their responses – their destiny; the individual participant's learning related to the 'how' and the 'why' of nurses as a driving force; the attitudes and beliefs of 'nurses taking charge'; insights, lessons, or legacies individual nurses and the profession might gain from nurses who made a difference. (See Figure Six.)

Figure Six: Square three on the quilt surface – Nurses as a driving force.

Wise decision-makers, that perceive themselves to be autonomous and accountable, are well placed to be in the driver's seat, to make things happen. Chapter six clearly highlights the primacy of the nurse – nurses in charge, nurses as drivers.

The fourth theme: **Creating a nursing future**, square four of the quilt. As each section of the 'quadditivity quilt' informs and is informed by each of

the other sections, the fourth theme used the first three themes to develop an understanding of the attitudes, beliefs and responses that the participants perceived were important **for** informing the futures they created, and lessons and legacies the participants would like to offer **to** the nurse of the future.

The four content areas of the chapter were: trends and patterns, movement through the past, the present to the future; an understanding of the legacies offered by the participants; lessons we can learn from the participants' own experiences; an exploration of new understanding and new meaning needed to underpin our likely futures, in the sense of desirable attitudes, beliefs and responses to ensure continuation of the primacy of the nurse. (See Figure Seven.)

Figure Seven: Square four on the quilt surface – Creating a nursing future.

By exploring how the profession and the participants in the study learned to make decisions, to be accountable, and to move forward, it is then possible to consider how we might create a nursing future as outlined in chapter seven. The attitudes, beliefs, and responses of the nurse as described in the theme chapters build the picture of the primacy of the nurse in the 1960s-1990s.

Before proceeding to the account of the nursing context and the theme chapters, the assumptions and limitations of the study are explored.

Assumptions and limitations of the study

The task of any researcher is to develop a sense of self-awareness of assumptions and perspectives in relation to the inquiry at hand. These then need to be made transparent to the reader. My beliefs and perspectives regarding the topic are expressed throughout this thesis, and the assumptions and limitations (in light of these assumptions) are linked back to the methodological principles previously outlined. The validity of the study is demonstrated by the congruence with the assumptions.

The process used in this study addressed the principle of understanding through investigation.

The **first assumption** is that the research question is an important question to ask. That by gaining an understanding of attitudes, beliefs and responses over time, we can learn from our past to inform our future. While I believe that the findings of this study support this assumption, I am also aware that the very shape of the question can influence the process. How I have worked to control such influences are described in the assumptions that follow.

The **second assumption** was that I was open to other views and the possibility of new information and new understandings. I began this study with a question that sought to explore factors that influenced the beliefs

and practices of the nurse in New Zealand so we could learn from the past to create a positive effective nursing future. At this time I believed that external factors (outside nursing) were a major influence on our beliefs and practices. I acknowledge my experience and knowledge of the nursing world, the influence my own past experiences had on my thinking and the lens I was looking through by making my choice of oral and written texts explicit.

My perspective comes from many years experience as a nurse involved in the context under study, personally familiar with many of the people and events, and reconstructing the pieces to form a picture that is my picture, my reconstruction of my interpretation of the understanding and meaning of the events that occurred over this time, within multiple contexts. I have worked hard throughout the research to continue to challenge my own standpoint and to respond to the various and diverse perspectives in the source material.

Being open to other views from a wide variety of sources meant that as I explored the evidence, a different perspective and new knowledge began to emerge. I utilised a process of analysing the material through a number of different filters, to explore and build ideas and new understandings in a careful way. This included taking notice of difference and considering what this means and being aware of the 'voices' used to inform the study.

The assumption that oral texts add a perspective not readily available in written texts was clearly demonstrated in this study and the voices of the participants added a richness and depth to the written texts. A question, however, was whose voice will be heard? Will the voice be informed? Is the voice one of 'power'? How would that differ from the voice of the 'dis-empowered'? What are the tensions between different voices? While I had sought to preserve a variety of voices within the particular group I

chose to study, the voices were all informed voices and could link the past through the present to provide some guidance for our future.

The **third assumption** is built on the premise that the study provided access to a wide variety of relevant oral and written texts. I was aware of the importance of diversity, the need to avoid following a single line of inquiry and this was made explicit in my selection of oral and written texts. The selection was chosen to provide information in principle relating to major events, trends and patterns relevant to the research question, and to provide a reasonable cross-section of source material. An important consideration was the achievement of a balance between the objectiveness of written texts and the more subjective oral histories.

The choice of the twelve oral history participants was a deliberate decision. I wanted a diverse group of nurses who were knowledgeable, and who had been working as nurses over the least three of the four decades studied. The choice of twelve participants was also personally manageable.

Their combined experiences nationally and internationally provided the 'big picture', the broad brush and their experiences as individuals provided the 'little picture' the specific detail. The diversity of the participants was also an attempt to gather a variety of views from nurses in education, clinical practice, management, politics, and nurse historians. While the participants were all leaders in their field, the variety of their work enabled the analysis of data across fields of interest.

My choice of participants limited the perspective to a particular group of nurses. I do not claim to represent the perspective of nurses from other backgrounds such as the staff nurse working in clinical practice over this period, the registered psychiatric nurse, or the nurse from a particular ethnic background such as the Maori nurse. I believe, however, that the

principal premise that we could learn from the past to inform our future could be relevant for all R.Ns.

The wide range of national and international texts and New Zealand public records provided differing perspectives over time and between the decades. The choice of nursing journals provided broad content on issues and concerns of the day along with personal viewpoints in editorials and opinion pieces. The ability to access international texts enabled me to confirm major trends and patterns and explored similarities and difference between nurses in New Zealand with those in other countries. In order to ensure the degree of diversity, I read as wide a variety of documents as possible. Where there were nursing journals published by different groups, it was useful to compare the focus of the editorial committee.

Written material about nurse and nursing in New Zealand written by nurses in New Zealand was not widely available. This was so especially during the 1960s and 1970s. This meant that the perspective of New Zealand nurses in these decades was mainly sourced from the *NZNJ* or papers presented at the few nursing conferences then available. The challenge in this research was to match or challenge the voice of the oral history participants with so little published material that reflected the voice of the nurse.

There has been a change in the 1980s and 1990s with regard to publication of paper presentations and research, although access to the wider nursing workforce is still limited. The use of papers presented at conferences and workshops enabled comparisons to be made between the voices, and an idea of trends to be constructed through the written sources.

New Zealand public records, particularly the Government departmental reports and the New Zealand Parliamentary Debates, became increasingly impersonal over time, and the value regarding attitudes and beliefs of

others related to nurses and nursing are virtually absent. Such comment is now found almost exclusively in nursing reports and policy documents. There was so much written background material available that in judging what to include, and striving to maximise information and detail I may have selected material that may result in some unintended bias.

The **fourth assumption** is linked to the premise that oral history as method can provide access to an understanding of the past, present and future. By using knowledgeable participants who experienced nursing during much of the four decades, I gained a perspective over a long period of time. The participants spoke about their perceptions of working from the time they were students up into the 1990s. This included perceptions of the profession as a whole, with both a national and an international focus.

By exploring the past, several participants could see trends and patterns in the responses of nurses in New Zealand, some of which were effective while others were not. When asked about the themes that had emerged, the nine participants who were interviewed again were all able to add new insights and understandings for me to consider, lessons and legacies from their own past experience. They had learned to respond in different ways and were able to articulate some of the attitudes and beliefs that could assist us to contribute to the continuing primacy of the nurse.

I do not believe that past trends can necessarily predict future events. I am, however, very clear that our attitudes and beliefs can predict future patterns of responses. That active responsiveness characterises the periods when we have moved forward.

The **fifth assumption** is about movement through the decades. The assumption is that by exploring change in and between the decades, we can reveal major trends and patterns, the big picture. Utilising oral and written texts these changes can be identified comparing the events as

recorded or recalled. It was important to recognise the power of published material in comparison with the oral histories over time. The written material is not diluted or distorted by time or memory whereas this is always a risk with oral history participants seeking to recall material from 30 – 40 years ago.

While acknowledging that oral sources enabled me to explore events through the experiences of those present at the time, time can distort the memory. In recognition of this possibility, I utilised the ‘test of verification’ mentioned by Christy earlier in the chapter, relating to whether I could describe material as factual.

The **sixth assumption** is linked to the use of the hermeneutic of actively recreating and reconstructing, enabling an interpretive exploration of the past that supported the premise that we can pull the ideas from the past through to the present to inform our future.

Using an adaptation of Droysen’s steps of interpretation, I was able to explore at deeper and deeper levels, and I was able to gather material to inform myself as researcher. Beginning with my own pre-understanding and then by exploring understanding of the context and sources, new understandings surfaced.

Working in a hermeneutic circle the patterns and themes are sifted, lifted and woven together to clarify the line of inquiry. This continued over several years until the evidence emerged that supported a central premise, the primacy of the nurse.

Chapter Three: The nursing context.

Having outlined the methodology, this chapter on the nursing context begins the creation of the account. The chapter provides detail about some of the important contextual events within the culture of nursing and serves to background the changing attitudes, beliefs and responses of the Registered Nurse.

To reiterate, I made a decision to write this chapter as a descriptive synthesis of the material rather than an historic account. The design of the chapter is to provide a context for the reader who is less familiar with nursing in New Zealand during the period 1960s – 1990s. Without this understanding of the events and the attitudes and beliefs underpinning the nurses responsiveness during the four decades, it could be difficult to position the material in the chapters that follow as assumptions about the context can be misleading. Those readers very familiar with the nursing context in New Zealand may choose to move directly to the theme chapters.

Methodologically the content in this chapter helps develop meaning and understanding through analysis involving a big picture focus, identifying major events from the source material. Events that influenced or impacted upon nurses and nursing, and provide the necessary background for the theme chapters. The major events were eventually processed into general ideas relevant to the nursing context and included the use of the title 'nurse', changes in nursing education, clinical practice, and nursing regulation.

Discussion of the term ‘nurse’ is included to outline the changes in the meaning and usage of the term as it evolved over time and to clarify the ‘proper’ use of the term in the New Zealand context. An overview of the changes on nursing education is an essential part of the nursing context as these changes pervade every aspect of the development of the nurse as an individual and the profession as a whole. Changes in clinical practice that followed educational change are included to demonstrate the growing professionalism of the nurse over the time period. Nursing regulation includes legislation, standards, and competence. Understanding the nursing context enables the reader to appreciate the development of effective decision-making professional autonomy and accountability, important underpinnings of the primacy of the nurse.

Two nursing organisations are also described (NZNO and the Nursing Council) because, while changes in education and clinical practice relate to both the individual and the profession, much of the work of the profession as a whole was done through these nursing organisations.

The process to enhance understanding of the context utilised four contrasting concepts applying these to the general ideas mentioned in the previous paragraph. The contrasts included movement within and between the four decades, 1960s-1990s, surfacing similarities and differences in trends nationally and internationally, the perspectives and actions of individuals compared and contrasted to those of the profession as a whole, and the big picture/little picture examples.

This exploration of contrasts enabled understandings to emerge that were at a deeper level than identifying the events alone. For example in exploring the title nurse, the international role of Flora Cameron, a New Zealand nurse became clearer. Her ability to understand the issues, to lead an international debate on the definition of ‘nurse’ to a successful conclusion, and then to bring back ideas to New Zealand of how we could

progress the debate, illustrated how a New Zealand nurse could function effectively, making a difference both nationally and internationally. By contrasting other events nationally and internationally it was possible to find occasions when New Zealand followed international trends and other times when New Zealand was a world leader.

Resulting from the gathering of the data in order to understand the context, questions surfaced about who or what really makes the difference? During the process of analysis the significance of the influence of the nurse gradually became self-evident. It became clear that it was primarily nurses that influenced progress within the nursing context. To position the chapter without acknowledging the primacy of the nurse, which becomes a critical aspect of this thesis, would distort the context. The chapter will therefore include aspects of the nurses' voice, which enhances understanding and adds to the authenticity of the account.

It was the nurses' responsiveness to the context that moved issues forward and brought about change. The individual and collective decisions and actions of nurses based on their attitudes and beliefs often influenced the context in which nursing took place. The culture of the nursing context emerges, contributing to the understanding of the context as a whole.

While the written sources provided important material about the events including some background, it was the oral histories that began to unfold and reveal the extent of the primacy of the nurse in many of the outcomes. The voices of the participants revealed the underpinning attitudes and beliefs that were reflected in the actions they took, the decisions they made, and the degree of urgency and resilience they displayed.

Particular attitudes and beliefs emerged as important if the responses were to result in effective action. Attitudes and beliefs that enabled nurses to be confident that their actions were the right thing to do.

An understanding of the nursing context during the period under study enables the changes in the attitudes, beliefs and responses of the nurse either as an individual or the profession as a whole to be better understood. The logical place to start is with a discussion of the term 'Nurse'.

The term 'Nurse'

Word usage changes over time, and it is only with knowledge of the context of the time that appropriate understandings emerge. The title 'nurse' has had different meanings over time, and still has different meanings that we need to be aware of internationally. We need to note that in reading about the 'nurse' in the 1960s and 1970s for example, the term was most often used as the title for students of nursing rather than the R.N. In the 1990s the term is legally protected and used only for the categories of nurse identified in the current Nurses Act (1977) as described later in the chapter. This section provides the knowledge of the context needed to understand the influences over time on the usage of the term 'nurse'.

The use of the title 'Nurse'

In this thesis the title 'nurse' is used to refer to the Registered General and Obstetric Nurse or her successor the Registered Comprehensive Nurse. Background to the titles used to describe the nurse in New Zealand includes reference to the 'proper' use of the title 'nurse', definitions, legal meanings, and people who have been influential in working with this concept or title 'Nurse'. The 'improper' use of the term both in New Zealand and internationally will also be described.

Registration as a nurse in New Zealand commenced in 1901 - the first country in the world to enact independent nursing legislation with a view

to establishing and enforcing minimum standards of practice (Dock, 1912; NZNA, 1984).

The Nurses Registration Act became effective on 1 January 1902 and thereafter those eligible for registration in the future had to be twenty three years old and have had three years consecutive hospital training, which included systematic instruction of at least twelve lectures in each of the three years. Finally they had to pass the examination set from time to time by appointed examiners.

(Burgess, 1984, p.86)

Despite the passage of the Nurses Registration Act, unqualified persons continued to practise as nurses over the next two decades (McDonald, 1993, p. 9). Since the first registration of a nurse was recorded on 10 January 1902, there have been a number of other registers established to meet perceived demand but the focus of this study is the Registered General and Obstetric Nurse and her successor the Registered Comprehensive Nurse.

International influence on the term ‘Nurse’

International people and events have always influenced nurses in New Zealand just as we have influenced nurses in other countries. Relating to the title ‘nurse’ and the importance of the nurse in health care worldwide, ICN and the World Health Organisation (WHO) were particularly important.

The influence of ICN on the title ‘nurse’ is illustrated by events in the 1960s. At a congress in Melbourne in 1961 ICN moved to define the registered professional nurse in the ICN constitution. While this did not eventuate participants “agreed that a generalised (comprehensive) nursing preparation was a standard to which most countries aspired and might reach in due course” (Salmon, 1984, p.133). This was a matter of some

concern for those countries, including New Zealand, who had several registers for different nursing specialities. Flora Cameron, Director Division of Nursing, representing New Zealand, became the Chairman [*sic*] of the influential ICN education committee, and at the congress in Frankfurt in 1965 she “led 6,000 nurses through the difficult discussions on the definitions of the professional nurse and basic nursing education” (Salmon, 1984, p.133).

Salmon (1984) records that the discussion of these definitions was very contentious and came near to splitting ICN asunder. She suggests that we should not underestimate the personal impact of Flora Cameron in achieving resolution to the debate. Although Flora Cameron’s sphere of influence was primarily in the 1950s and early 1960s she is an example of a New Zealand nurse whose personal leadership was expressed and appreciated both internationally and nationally. In 1978, Elizabeth Orbell in a speech paying tribute to New Zealand nurse leaders of the past included Flora Cameron on her list of nurses

without whose vision, enthusiasm, fighting spirit and complete dedication to a better education for nurses we would never have the high standard of nursing service that is taken for granted today.

(Orbell, 1978, p.18).

It was from this framework of experience and beliefs that Flora Cameron influenced the New Zealand nursing context until her death in 1966.

The definitions of the ‘first ‘and ‘second’ level nurse adopted in 1965 by ICN under the guidance of Flora Cameron have had considerable influence in New Zealand in the latter half of this century. These definitions for the first and second level nurse were subsequently used by the WHO Expert committee on nursing and incorporated in it’s influential report known as the ‘Fifth Report’ (World Health Organisation, 1966).

This definition for the first level nurse (which in New Zealand is the Registered Nurse) was:

The nurse is a person who has completed a programme of basic nursing education and is qualified and authorised in her own country to supply the most responsible service of a nursing nature for the promotion of health, the prevention of illness, and the care of the sick.

(WHO, 1966, p.32)

Salmon (1984) in writing about this period suggests that like its four predecessors, the WHO 'Fifth Report', which emerged in the early part of the time period under study,

has had a widespread influence on nursing service and nursing education in New Zealand and other countries throughout the world...and was used at the time the New Zealand government made the decision to transfer nursing education into the general system of education and when various statements and policy documents have been prepared by the NZNA.

(Salmon, 1984, p.134)

After acceptance of the definitions of 'nurse' in 1965, and the WHO use of the definitions in the 1966 'Fifth Report', there was a relatively quiet period internationally relating to the title 'nurse' until the matter was addressed again in the 1980s. Margretta M. Styles undertook on behalf of ICN a project to assist develop an ICN position on the future of regulation in nursing. This resulted in an ICN position approved by the Council of Nurses Representatives in 1985.

ICN therefore retires the terms first and second level nurse and nursing and reverts to the generic terms 'nurse' and 'nursing auxiliary' for designating two categories of nursing personnel, and will define the role and preparation thereof. ICN recommends for the nurse...the universal title 'nurse'.

(Styles, 1986, p.47)

Included in the report on *The regulation of nursing* was a statement on nursing personnel in a section on guidelines for national nursing regulatory models. "Nursing personnel should be of three general categories: nurses, nursing auxiliaries, and nurse specialists (post-basic) with nurses at the centre of the professional and regulatory structure" (Styles, 1986, p. 48).

Ten years later, in 1995, ICN members adopted a position statement on *The Title of Nurse* which included "persons receiving care have a right to know the qualifications and competence of the health personnel they are dealing with and have confidence in that competence" (ICN, 1995, p.233).

Titles convey this message and the title 'nurse' serves that purpose for the nursing profession internationally and nationally. Moreover, to protect the public, nurses in most country's practice under some form of statutory regulation and have a scope of practice defined by law. This makes nurses legally accountable for all practice within this scope.

In 1999 the Governing body of ICN, the Council of Nurse Representatives (CNR) approved the following definition of 'nurse' for membership purposes. "A nurse is a person who has completed a nursing education programme and is qualified and authorised in her country to practise nursing" (ICN, 1998, p.4). This reflects the need to define 'nurse' as representing a qualified nurse while acknowledging that the complexity of regulations and nursing practices in different countries make it impossible to link the definition to a universal standard of education or training.

In New Zealand the current use of the term ‘nurse’ is found in the New Zealand Nurses Act 1977 in the section outlining the Title of the bill, (Clause 2. Interpretation), where the legal definition of the nurse in the Act is ‘Nurse includes a registered and an enrolled nurse’. There are currently seven categories of ‘nurse’ used in New Zealand as shown in Table One.

Table One:

Current categories of ‘nurse’ in New Zealand

Registered General Nurse
Registered General and Obstetric Nurse
Registered Comprehensive Nurse
Registered Psychiatric Nurse
Registered Psychopaedic Nurse
Registered Obstetric Nurse
Enrolled Nurse

There have been many submissions made over the years related to the need for a review of the 1977 Nurses Act suggesting, among other changes, the need to consolidate the titles and categories. While New Zealand nurses may no longer register under any category other than the Registered Comprehensive Nurse, overseas immigrant nurses may still be registered under the other categories. By 1990, programmes were no longer offered in New Zealand for any of the categories other than the Registered Comprehensive Nurse, and in the 1990s usage of the generic

term 'Registered Nurse' or R.N is commonplace. Historically the term 'nurse' has been used very loosely. Senior nursing personnel, other health professions and health workers, as well as the patients often referred to student nurses in the 1960s through to the 1980s as 'nurse'

The correct 'proper' use of the term 'nurse', and the protection of the title is becoming more accepted within the profession, as people recognise that there is a legal definition and protection of the title 'nurse' in New Zealand.

The term is still used rather casually by those working to assist other professionals such as doctors, dentists, veterinarians, as well as by unqualified caregivers in private hospitals and rest homes. This is despite a clause in the 1977 Nurses Act outlining restrictions on the use of the title 'nurse' (Nurses Act 1977, Part VII clause 52.) This is not a problem confined to New Zealand. In the ICN study, *The regulation of nursing*, referred to earlier, the author commented that

nursing was found to be a profoundly and confoundingly heterogeneous profession, both within and among countries. Diverse personnel - variously prepared, variously credentialed, and variously responsible - are engaged in its practice. Taken in its totality worldwide, regulation has created and reinforced in nursing a melange of categories, career patterns, and standards.

(Styles, 1986, p.20)

The importance of considering the title 'nurse' is to note that the term has been used 'improperly' over time. This is still the case internationally where there is little or no nursing regulation. While there is legislation that restricts the use of the title and defines who may legally use the term 'nurse' in New Zealand, internationally this is not always the case, so reading international texts necessitates an understanding of how the term is being used by the author. The history of the use of the title 'nurse'

demonstrates changing attitudes and beliefs over time, responding to changes in the professionalisation and scope of practice of the nurse. Currently the title implies qualifications and authorisation to practice nursing in New Zealand. In this thesis, I am using the title 'nurse' in every instance to refer to the New Zealand Registered Nurse, registered under the category of either a Registered General and Obstetric Nurse (R.G.O.N) or a Registered Comprehensive Nurse (R. Cp. N).

Having provided some background to the use of the term 'nurse' in New Zealand, the next section addresses the major changes to the nursing context over the four decades in relation to nursing education.

Major changes in nursing education

Nothing demonstrates the changes over the decades in New Zealand more clearly than an exploration of nursing education (Appendix Five. The anticipatory planning years in the 1960s, the tensions and heady days of change in the 1970s, a consolidation period in the 1980s, and in the 1990s the achievement of a degree qualification in nursing as the basic requirement for registration. This section is important to provide the context of the changes that influenced responses in nursing practice and nursing regulation over time, especially with the withdrawal of the student workforce from the hospital setting. It is essential to understanding the primacy of the nurse within these events and it provides background for the changes in clinical practice that followed.

This section is divided into two major topics, 'basic' education, and post 'basic' education. The section on 'basic' education includes an introduction to the term, key events over the four decades in the development of schools of nursing as well as changes in educational approaches and teaching methods over the time period.

‘Basic’ nursing education

The term ‘basic’ nursing education is used in this section because it was the term used in the literature for much of the period under study to refer to the education programme offered to the student prior to registration. The question of what ‘basic’ really means has often been raised (ICN 1999). In 1984 the term was still used in NZNA policy documents “basic education is concerned with the preparation of the first and second level nurses” (NZNA, 1984, p.16). Today all nursing programmes leading to registration also offer a degree qualification. We now use the term undergraduate education to refer to the programmes preparing the student for nursing registration.

‘Basic’ programmes or courses for nurses in New Zealand began in 1889 with certification by a hospital (Wellington in 1889, and Auckland in 1891). They were based on the Nightingale model “preparing carefully selected women to provide safe and efficient nursing care to the community. Her education programme was geared to meet the needs of the people of the day” (NZRNA, 1965, p.4). Initially the schools retained independence from the nursing service administration, but gradually the demand for nursing service led to hospitals adopting an apprentice system and this became accepted as the predominant system of nursing education in most of the British Commonwealth countries.

Following the Nurses Registration Act in 1901 some national uniformity developed through a three-year hospital nursing course followed by a state examination for registration (Burgess, 1984, p.61). This programme remained relatively static with only minor changes to the number of theoretical hours of study, and extensions to the curriculum until 1973 (Rodgers, 1985). The roots of New Zealand nursing education and practice were drawn from Britain, and Yvonne Shadbolt described that it

was a revelation to her when she worked as a nurse in England in the early 1960s

to see how deeply entrenched our roots were and how in fact I rather thought that I was looking at some of the history of nursing that I'd heard about.

(Shadbolt, 1:1)

Ever since recognised nursing education programmes leading to registration began, there has been debate about nursing education and in the 1930's for example at one NZTNA conference approximately 50% of the remits concerned the 'basic' curriculum. Pre-nursing preparation, a compulsory preliminary training period, and inclusion of community health teaching were among the issues discussed (McDonald, 1993, p.53). This debate about nursing education continues today with a review planned in the year 2000.

The development of schools of nursing

Schools of Nursing in New Zealand have changed markedly over the four decades with major developments in the 1970s when the transfer of nursing education to the tertiary education sector began. Prior to the 1970s, nursing education offered in hospital based schools of nursing largely developed in terms of expediency based on nursing service demands and the functional purpose of the hospital rather than on educational opportunities. Carroll (1984), writing about the past 75 years of NZNA describes how in the early years the New Zealand Nursing Journal *Kai Tiaki* was "liberally sprinkled with letters to the editor expounding the value of training in small hospitals and in private hospitals or arguing for the development of nursing education in major institutions only" (Carroll, 1984, p.64). The schools of nursing were owned and operated by hospitals; those in training were employees of the owning authority; and the schools primarily existed to provide an immediate

staffing resource for a specific hospital (Shadbolt, and Shaw, 1987). In 1960 for example when shortages of nurses were debated in Parliament a suggestion was made to build a local hospital in Horewhenua to “help provide employment in a noble profession for girls in the area”. While this may have been initially justifiable because of New Zealand’s small scattered population and transport difficulties, by the end of the 1960s the number of schools was perceived as wasteful of resources particularly in relation to qualified nurse teachers (Department of Health, 1969).

International influences were significant right from the beginning. The status of the New Zealand education programme in comparison with overseas was an issue raised in the early days (Bicknell, 1940; Lambie, 1951) but it was not until the 1960s that nurse leaders in New Zealand began to express the view that our programmes should be primarily designed to meet the health needs of New Zealanders rather than ensuring we met the content requirements that enabled reciprocal arrangements between country’s especially between New Zealand and the United Kingdom (Orbell, 1965).

During the 1960s in particular many people commented on or about nurses and nursing. The politicians and the medical profession participated in the debate usually as a result of invitations to address the New Zealand Registered Nurses Association (NZRNA) conference, graduation ceremonies, or the Matrons’ conferences. In a 1964 address to the Hospital Matron’s Association, Dr Wilton Henley, the Medical Superintendent of the Auckland Hospital Board, concluded that as a result of his reading nursing journals over the past few months,

there is no more uniformity of opinion about nursing education than there is uniformity of nursing practice in New Zealand. In your present deliberations, I hope you will concentrate on principle

rather than expediency, and emphasise points of agreement rather than difference. What will give the best services to the patient? How can nurses best be educated and prepared to give that service? The raising of standards should be a continuing objective in all grades of nursing.

(Henley, 1964, p.9)

In 1969 there were 62 schools offering 139 'basic' nursing programmes and the Department of Health in a 1969 publication titled *A review of hospital and related services in New Zealand*, highlighted many issues of concern about nursing education at the time. Extracts from the report are set out below, and many concerns were mentioned by the participants in various parts of this study.

In the existing three year programmes it is not possible adequately to prepare nurses for first level positions in a comprehensive nursing service in which they are required to assist in a responsible way to promote health, prevent illness and care for the sick...There are serious restrictions on what it is possible to teach or learn because of the large amount of hospital nursing service given by students in excess of their preparation and because the orientation is towards giving this service. It is not possible to incorporate the recent major advances in knowledge in general and specifically in medical knowledge and the effect on nursing practice. In spite of the outstanding efforts of the staffs of schools of nursing, the gap between new knowledge and its practical application appears to widen rather than decrease...The clinical content of programmes is largely geared to the nursing service demands of the employing hospitals...As a result theory and practice are largely divorced...In the clinical field nursing service tends to take precedence over nursing education; many students are required to take responsibility beyond their preparation and much of this care tends

to be under-supervised...Some hospital administrators are now encouraging married students to complete their programmes but in many schools little encouragement or consideration is given to married students in the way of administrative reorganisation to suit them.

(Department of Health 1969, p.42-43)

This wide ranging report emphasised the need for improvement in the system of nursing education, reduction in the number and variety of schools of nursing, university preparation for nurse administrators, educators, and researchers, and comprehensive preparation for the first level nurse. Shadbolt (1983), writing about the transfer of nursing education, describes the report as unambiguous, honest and punchy, anticipating the 1970 Carpenter Report in almost every detail, but no action was considered possible at that time in a climate greatly influenced by local hospital boards who focused on their own short term needs.

Major events over the four decades.

The 1960s

Shadbolt (1983) in writing about the history of the transfer of nursing education outlined a number of important events in the 1960s. These included an increase in the growth and complexity of services provided by the hospitals, increased bed turnover, insufficient people well prepared enough to meet the demand and major problems with attrition from the three year programmes. Ann Nightingale spoke of the huge burst of knowledge over this period in basic sciences and the resulting changes in education. In 1964 the uncertainty about the quality of nursing education spread beyond a minority leadership and interested few. NZNA embarked on a struggle to establish a mandatory minimum education standard (School Certificate) for entry into the general programme.

Three year basic nursing programmes were offered by hospital based schools of nursing throughout the country and reports, reviews and opinions regarding the state of nursing education were not very positive (*Shadbolt, 1:1*). During the decade many nurses raised the perceived need for basic nursing education to be within the tertiary education sector. New Zealand nurses wrote and talked about their concerns (Cameron, 1959; Orbell A., 1965; Orbell E. B., 1960; Salmon, 1962, 1969). These New Zealand nurses were supported by international visitors (Chittick, 1969; Reid, 1965), international reports (Salmon, 1984; WHO, 1966), and the NZRNA. The NZRNA reported comment in *The New Zealand Nursing Journal: Kai Tiaki* from the Presidents and other nurse leaders of the day, as well as recommendations from NZRNA annual conferences.

In 1965 The Nurses and Midwives Board launched the 'Blueprint for nursing education in the 1970s', which advocated a 'comprehensive approach to nursing education'. The committee that wrote the report included some of the most powerful nurse leaders in the country and yet they were unable to bring about the change they sought for several years.

The Hospital Board schools were under the control of the Matron (the senior nurse administrator within an organisation) which led to a conflict of interest between the educational needs of the students and the nursing administrations' need to adequately staff the hospital. The Matrons were in a difficult situation being required to staff the wards day and night, weekends and public holidays included, and at the same time they were expected to be more selective from the inadequate numbers of candidates offering.

The educational approaches and teaching methods used in nursing programmes were linked to developments in education and demand to meet service needs. Hospital schools of nursing began their programmes primarily to meet their workforce needs. Pat Carroll, in writing about

early times, quoted articles in *Kai Tiaki* indicating that even in 1918 this was perceived to be a concern.

The nurse had primarily been seen as the servant of the patient or the handiwoman for the hospital and her training was always a secondary consideration. The strain of attempting to attend lectures during work time or following up on a busy clinical day, as well as the folly of not assigning regular off duty periods and days to the students was criticised.

(Carroll, 1984, p.65).

The 1960s saw teaching approaches as predominantly 'lecture' style with clinical skills taught in a 'demonstration room' based on procedure books detailing the 'one right way' to carry out a particular skill. Nationally the requirements of the State [national] examination influenced both the content and design of nursing courses and the influence of the medical profession was evident in their contribution to the writing of textbooks for nurses and the lectures they gave to the students in school. The students took notes from the Tutor Sisters who used the textbooks written by doctors that focused on disease and its management. Clinical experience to meet the needs of the hospital employer meant that theory and practice were not integrated, and the teaching staff very rarely spent time with their students in the wards. To assist students link theory and practice some schools introduced Clinical Tutors based on the United Kingdom model, but the introduction of a 'third party' (who worked in the wards without necessarily being clear about the links between theory and practice for specific students), did not seem very practical in New Zealand and gradually those positions ceased to exist.

Despite the recognition by the policy makers and many nurse leaders of the day that improved educational attainment was important if nursing and New Zealand nurses were to progress and cope with the rapidly changing

times, there was little support for individual effort. Mia Carroll talks of the negative attitude to education while she was a student, and the struggle she had to enrol in university study part-time. The then Principal Nurse of her hospital questioned her intelligence asking

what made me think I had the intelligence to do so – so there was not an abundance of encouragement to advance oneself in a tertiary setting and there were lots of obstacles added. You were given no privilege of shifts and I remember the Principal (a different one by now) fighting to get me off night duty so I could sit my final exams.

(Carroll, 1:3)

Another issue that was significant in this period was the lack of educational preparation of the nurse educators. In the late 1950s early 1960s Jocelyn Keith described her nurse teachers as having neither teaching qualifications, nor graduate educational qualifications. This was typical of the time and very significant for Jocelyn as she felt she learned far more from the nurse in clinical practice than the tutor in school. She suggested that if she had only considered her education experience, she would never have got hooked on nursing. Jocelyn was involved in the national student nurses association at this time.

We had some in-depth conversations re the inadequacy of the curriculum as it was – and there was general sympathy around the country for the hopelessness of the programme for the careers we were planning – we wondered why we went to [nursing] school at all – it didn't seem to have any relevance.

(Keith, 1:2)

The formal qualifications of nurse tutors had not improved by 1970 when figures provided by the Department of Health for Dr. Helen Carpenter showed that the qualifications of the nurse tutors compared unfavourably

with secondary school teachers. Only 29.7% of nurse tutors had the minimum recommended qualification of a diploma from the School of Advanced Nursing Studies, and only 21 of the 343 tutors were enrolled part time in a university programme. (Carpenter, 1971).

Events to note regarding developments in Schools of Nursing in the 1960s, are the concerns about the effectiveness of a student nurse workforce with many New Zealand nurses expressing concerns about the inability to meet the increasing complexity of hospital services. Overseas nurses visiting New Zealand supported these concerns. Nurse educators and nurse leaders in the hospital services recognised that changes in educational preparation of both nurse educators and nursing students was required to cope with rapidly changing times. The profession as a whole was ready for the change the 1970s would bring.

The 1970s

Many nurses put considerable effort into influencing government policy regarding nursing education throughout the 1960s and along with the publication of the Review of Hospital and Related Services in New Zealand (1969), outlining clearly the need and desire for change, the 1970s was the time that major change was initiated. This was perceived by many to have been triggered by the report of Dr. Helen Carpenter, the Director School of Nursing, University of Toronto, who visited as a WHO short-term nurse consultant. Dr. Carpenter was requested by the government to study New Zealand's nursing education system, and her recommendations relating to the transfer of nursing education from the hospital board schools of nursing to the tertiary education sector were significant for the future of nursing education in New Zealand. The 'Carpenter Report', however, was of no great surprise to those who had been involved in the efforts to bring about change during the previous decade.

The Annual Report of the Department of Health, in the year the Carpenter report was published, stated

the response to the report was overwhelming and while there might be disagreement on some of the details of it, there is substantial agreement by all interested groups that major changes must be made in the system of nursing education.

(Department of Health, 1971)

In 1985, nearly fifteen years later, the authors of a Department of Health workforce planning report suggested that the response to the Carpenter report was rather more controversial than the department initially acknowledged. It was “considered to be quite controversial and provoked considerable discussion throughout the country not only among nurses but also within other health professional groups” (Department of Health, 1985, p 25).

However, following the publication of the report, and a concerted effort by many New Zealand nurses, the Government decided to pilot nursing courses in the tertiary education sector. In 1973 the first two courses providing a Diploma of Nursing and registration as a Comprehensive Nurse began in Wellington and Christchurch Polytechnics in March, alongside two university programmes for Registered Nurses offered by Massey University and Victoria University of Wellington.

Two further pilot programmes were approved in 1975, and following an assessment of the four pilot programmes (based in Auckland, Wellington, Christchurch and Nelson), the Government in 1977 announced its commitment to transfer responsibility for all nurse education from three-year hospital-based programmes to polytechnics. This was a very welcome development for those nurses who had fought long and hard for the changes in nursing education to be accepted by all the policy makers. Nursing as a whole was fortunate in its leaders of the day who were able

to persuade the politicians to back the changes despite some vociferous opposition.

Marie Burgess spoke of the value of the broad preparation offered by a comprehensive programme. This belief was one of the reasons for her joining the staff of one of the schools in the early stage of the transfer.

It seemed a very good way particularly as the new programmes were billed as having a broad and comprehensive preparation for nurses including community health nursing which would mean people [nurses] would be able to go in theory at least [after graduation] straight into the community.

(Burgess, 1:6)

She also spoke of the tension in those early days when the programmes were 'pilot' programmes and those involved did not know what was going to happen with any certainty from one year to the next..

We didn't know from one year to the next for a considerable number of years whether it [the course] was going to continue, whether there was funding for another year, whether we could take in another intake, or ... how the evaluation was going to work. There was much tension during the year, much talking and discussion and handwringing and going off to see people trying to get the decision made.

(Burgess, 1:6)

Anne McDonald described how tutors at the School of Advanced Nursing Studies had wanted a plan for the transfer.

They (the nurse tutors) advocated a plan that there should have been a total plan for the transfer of the schools of nursing to the polytechnics with – that by the year such and such we would have

four programmes or whatever and we would have them in these kind of areas. It never happened that way. It was introduced in a very haphazard [way]. The fact that we got 15 schools was never right. It should never have been [so many].

(McDonald, 1:2)

With no date set for completing the transfer, for a number of years a dual system of nursing education operated, with hospital-based three-year programmes phasing down at varying speeds, while the technical institute courses increased. By 1986, 15 polytechnic nursing departments had been established throughout New Zealand (Department of Health, 1988).

In the 1970s there was a clear shift in teaching approaches from a 'medical model' focusing on the diagnosis of disease and its management, to a 'nursing model' with a focus on the patient and their care and studying health promotion, disease prevention, care and rehabilitation. There was a move away from a standard way of doing things to teaching by principles, for example principles of asepsis or a more holistic approach to the care of patients according to their individual daily needs. This necessitated an understanding of problem solving and tools such as taking a patient history, the nursing process, and care plans were introduced. Theory and practice were integrated through a variety of nursing models and for the first time many students had their teachers with them in the clinical area helping consolidate their learning. Details of this period have been documented by several New Zealand nurse educators (Christensen, 1984; Perry, 1985; Shadbolt, 1983).

Events in the 1970s saw a response by the profession and the policy makers to the concerns of the 1960s. The 'Carpenter Report' was the trigger for change and during this decade the transfer of nursing education from the hospital board Schools of Nursing to the tertiary education sector began as well as the beginning of university education for the R.N. A

response to the actions of nurse leaders in initiating major change and demonstrating primacy.

The 1980s

For the majority of the 1980s the technical institute programmes consolidated their work with the three-year comprehensive programme, and the hospital schools either closed as the technical institute programmes grew, or worked to control numbers in partnership with the tertiary education sector. Over time Registered Nurses, many from the comprehensive programmes, replaced students as the providers of nursing care in the hospital. Students from the polytechnic courses were not employees of the hospital nursing service and they gained experience in a variety of healthcare settings with specific goals that linked theory to practice with the help and support of the polytechnic nurse teachers.

Government policy towards deregulation in the late 1980s meant that many national systems were decentralised and regional or local systems established. This applied to both the Education and Health sectors. Significant databases held by central Government were dismantled or no longer used and among the important databases affecting nursing were the systems associated with workforce planning. Control of numbers entering the nursing workforce passed from the Education and Health Departments to the education providers. It became a matter for the local market. Access to national statistics became more difficult as no one department accepted responsibility for national collection and processing. The last major workforce-planning document affecting nurses was published in 1986. The numbers entering nursing programmes in the polytechnics now varied from year to year along with the restructuring of both education and health sectors.

Events related to basic nursing education in the 1980s were primarily consolidating the major changes initiated in the 1970s. The lack of a plan

to complete these changes prolonged the transfer and meant that a dual system of nursing education operated until the late 1980s. Indications of major structural change associated with the government policy of deregulation caused some uncertainties especially related to workforce planning and centralised databases.

The 1990s

Two developments in Schools of Nursing in the 1990s have changed New Zealand nursing education in a major way and contributed to the growth of the profession. The first is the groundbreaking work on the concept of 'cultural safety', and the second is the granting of a degree in nursing as a prerequisite to register as a nurse.

In 1986 a workshop had been held to review the preparation and initial employment of nurses. One of the recommendations under the heading of 'Promotion of a bicultural attitude and multicultural sensitivity within the health service', was recommendation 38: "that nursing education and nursing service be committed to biculturalism" (Department of Health, 1986, p.68).

This was in tune with the commitment of the Government of the day to honour the Treaty of Waitangi (an historical document of special significance to New Zealand and considered by some as part of our constitution). This commitment was "derived from the Government led social and health initiatives to improve the health outcomes for all people of New Zealand" (Nursing Council, 1996, p.7). The nursing and midwifery professions debated this commitment and in 1990, the Nursing Council provided leadership for the profession, by amending its Standards for registration to incorporate the concept of 'cultural safety' in the nursing curriculum. This was a response to the belief that evidence of culturally safe practice should be a pre-requisite for registration as a nurse. In November 1992, 20% of the state examination was to pertain to

nursing Maori people in a culturally safe manner (Nursing Council, 1992). The inclusion of 'cultural safety' in the curriculum and its implementation was a world first in nursing education. It has been a controversial move, but has stood the test of time and is now a feature of nursing in this country, and a model for other countries.

Guidelines for cultural safety in nursing and midwifery education were published in 1996, and the requirement for the nurses to practise in a manner which the client determines to be culturally safe are included in the competencies for entry to the register of comprehensive nurses (Nursing Council 1999, p.8). The impact of this requirement means that all R.Ns are required to be familiar with the Treaty of Waitangi, and to apply the principles of cultural safety in their practice.

The second major development affecting nursing education in the 1990s was the passage of legislation that enabled the polytechnic sector to offer degrees.

The Education Amendment Act 1990 established several new entities including the New Zealand Qualification Authority (NZQA), an organisation charged with development of a national framework for educational qualifications in New Zealand. This legislation, among many other things, also enabled the tertiary polytechnic sector to offer degree programmes approved, accredited, and monitored by NZQA.

*I think [the ability to offer a nursing degree] was the proper thing to happen and quite frankly recognised what was a de facto condition. The reason we didn't have nursing education in New Zealand in the 1950s and 1960s of the same style, quality, setting, and everything else [of] any other health professional was because of the **numbers** and the way nurses were **used** and I mean used. By the time we got to the late 1980s nurses were undergoing an undergraduate level programme of the same standard and demand*

as any other undergraduate programme in the country but were still denied the qualification that was anybody else's of right for going through on a full time professional pre- service programme.

(Shadbolt, 1:14)

Very quickly the nurse leaders in the nursing departments at the Auckland Institute of Technology, Wellington Polytechnic and the Otago Polytechnic, set in process applications to offer a Bachelor's degree programme in nursing, associated with registration as a nurse; these applications were approved by NZQA. By 1995 the market demand had resulted in all fifteen polytechnics in New Zealand with nursing programmes offering three-year degree programmes for their nursing students, not without some controversy and questioning whether this was the right response. These degree programmes led to registration as a Comprehensive Nurse – the only nursing registration programme now offered in the tertiary sector. The profession during the 1990s has made several efforts to work collectively for the future of nursing education, particularly the conference 'Vision 2000' held in Auckland 14-16 March 1991. While some 'consensus conferences' addressing issues of concern have been held throughout the decade, the current perceived competitive climate in the education sector, associated with deregulation and lack of central workforce planning makes collective planning and action difficult. No consensus has yet been reached of how to move forward for the benefit of the profession, despite the efforts of many nurses over time.

In 1998 a Ministerial review of nursing in New Zealand was undertaken with the establishment of a Ministerial Taskforce on Nursing set up to address "obstacles to the nursing profession realising its full potential with respect to health service delivery" (Ministry of Health, 1998, p.3). In relation to nursing education, one of the recommendations sought to review the number of polytechnics offering undergraduate nursing programmes for the purposes of ensuring the provision of education and

clinical experience of a high quality which matches the needs of the health and disability services sector (Ministry of Health, 1998, p.19).

Some of the concerns expressed in the taskforce report were reflected in comments by Colleen Singleton (1998), written as she was retiring as the Nursing Council Executive Officer,

nursing still has to deal with the recurrent thorny issue of a national curriculum, too many nursing schools, variance in nursing programmes, graduates who are perceived as 'not up to it'...graduates cannot be expected to hit the floor running.

(Singleton, 1998, p.3)

Alongside the Ministerial Taskforce, the Nursing Council also decided that it was time for a review of nursing education.

Nursing Council audits of programmes have raised issues. Members of the Council in practice have said it is time to look where nursing is actually going in the next century and what implications that will have for nursing education.

(Clark, 1999, p.12)

NZNO welcomed the review, as did several Heads of Schools of Nursing, and the NZNO National Student Unit. The Student Unit Chairperson, Davina Jones, was quoted in *Kai Tiaki: Nursing New Zealand* as saying that such a review was needed because there were too many schools, securing jobs was a battle for many new graduates, and the quality and delivery of clinical placements was too often inadequate (NZNO, 1999, p.12).

During the 1990s there was a significant shift in teaching approaches. The shift was from the concept of received knowledge, to the concept of the self-directed learner, reflecting the gradual development of the discipline of nursing. The importance of 'journalling', 'critical thinking' and

‘reflective practice’ was acknowledged and taught in nursing programmes alongside the adoption of problem based learning, which encouraged dialogue and recognised the multiple realities of patients’ experiences. Several nursing curricula prepared in the early 1990s for approval and accreditation, and examined by me personally when on the Board of NZQA, included extensive documentation about how the skills of reflective practice and critical thinking would be taught to nursing students.

In the late 1990s, the increasing complexity and acuity of patients and the shortage of experienced nurse mentors meant that the teaching of clinical skills needed a variety of innovative approaches to be developed. These included clinical simulation in laboratories and interactive use of computer programmes and video presentations.

Events in the 1990s affecting Schools of Nursing continued the changes that had taken place over the previous three decades. With continued decentralisation of data bases have meant we often have to rely on anecdotal data, which impairs our ability to make effective decisions. Nurses in both education and management are working together to obtain data to inform their planning and decision-making so that nursing education will continue to be responsive to the needs of the health service and by implication the health of the peoples of New Zealand.

Basic nursing education has changed markedly from the hospital programmes with the student as an employee providing service in the 1960s to the student as learner in the Tertiary education sector in the 1990s. The significant role of the individual nurse and the profession in bringing about those changes in the face of widespread opposition from some quarters clearly demonstrated examples of the primacy of the nurse during these four decades.

Post basic education

Like 'basic' education, the educational opportunities for the R.N saw the culmination of many nurses' efforts over time with the introduction of university programmes offering undergraduate and post graduate study in the discipline of nursing in the 1970s. Efforts in the early part of the twentieth century took some fifty years to offer real choice to the NZRN, with many leaders of nursing in New Zealand devoting much time and effort to bring about change and move the profession forward. The 1970s saw the beginning of a diversity of choices for the R.N and a major uplift for the professional development of the nurse in New Zealand.

The term post basic education in this thesis is used to mean any educational opportunity for the nurse following registration. In New Zealand such education has had a rather chequered and latent development, not unlike the development in Australia and the United Kingdom but well behind developments in North America. This section also outlines early efforts to establish university education for nurses and developments up to the late 1990s.

The beginnings – seeking university education opportunities

The history of basic and post basic university educational opportunities for nurses in New Zealand is particularly interesting with several efforts to establish university education for nurses in New Zealand beginning in 1912 (Miller, 1984). The idea was

mooted for nurses in New Zealand by a Dr. J.C.Pabst in a speech at the opening of a nurses' home in Auckland. Reaction varied, but the intervention of war put such matters out of the minds – temporarily at least – of the few enthusiasts.

(Burgess, 1984, p. 70)

In 1922 at the NZTNA conference a remit was proposed that cited recent developments in nursing education overseas – in Leeds, British Columbia, and the United States and requested that active steps be taken to have nursing similarly recognised by a University in New Zealand (McDonald, 1993, p.53). Jessie Bicknell was appointed Director of the Division of Nursing in 1923, and had been inspired by what she had seen and learned overseas – she was interested in establishing a post graduate school for the Registered Nurse, in connection with a New Zealand university (Cameron, 1959).

The official view of the history of early developments was outlined as follows in the 1969 review by the Department of Health.

In 1923 the NZTNA sent a strong recommendation to Government seeking the establishment at Otago University of a School of Nursing. In 1925 Otago University approved a five-year programme leading to a Diploma in Nursing, with students entering the Home Science School for the first two years. In 1927 difficulties arose, as Otago University decided that it could not finance the salaries of the nurse lecturers and so the programme lapsed...thus died a basic programme in nursing within a university...New Zealand could have been a leader in university preparation for nursing. Now 43 years later she is almost without exception lagging behind all other high-income countries and many low-income countries in not offering university education in nursing for at least a small percentage of nurses. It is significant that “underdeveloped” countries have this kind of preparation for some of their nurses.

(Department of Health, 1969, p.18–19)

It is interesting to note the similarity of development in Australia. Godden, Curry, and Delacour (1992) comment that on 15 May 1912, the

Australasian Nurses Journal ran an editorial arguing for a Faculty of Nursing at Sydney University. They suggested that the question that should now be asked is - why did we have to wait so long? (University education for R.Ns was not established until the 1980s in Australia).

The late 1950s and 1960s saw renewed interest among some nurse leaders in the effort to move some nursing education into the university setting. When the Director Division of Nursing, Flora Cameron returned from attending the Florence Nightingale Education Committee of ICN in 1959, she made a plea to the NZRNA conference for support for a university course to which potential leaders would be sent.

What we require is a Chair of Nursing in a university. Other professions have it. Why not nursing? We want nursing recognised *as nursing* at university level. We do not want nursing attached to some other established department or unit of the university. This would retard its progress. It is important in my mind that it is 'Nursing' which should be recognised as worthy of a place among the other professions...We as nurses must lead our profession - not wait to be led by others.

(Cameron 1959 p.75)

I note with interest the last sentence in this quote – the recognition that we as nurses must lead our profession, that we must be actively responsive to the issues of the day, one of the premises on which this thesis is built.

The conference supported Cameron's resolution, moving that the Nurses Association take immediate steps to establish a Chair of Nursing in a New Zealand university. Discussions with Victoria University of Wellington began and in 1960 a proposal to institute a School of Nursing within Victoria University of Wellington was forwarded to the University Grants Committee for approval (Miller, 1984). Unfortunately the proposal was not accepted "in view of the country's economic position." Throughout

the 1960s nurses continued their support for a university nursing programme and put energy into lobbying both universities and government, fund raising, and providing scholarships to support nurses undertaking university study both in New Zealand and internationally, particularly in the United States of America.

It was recognised that if nursing was to move forward, New Zealand nurses had to be better prepared for leadership in nursing. Nurses individually and on their own initiative went overseas to gain additional qualifications. Some nurses in New Zealand began university study in other disciplines.

The New Zealand Post Graduate School for nurses, established in 1928, was the only educational facility in New Zealand for nurses to obtain a national postgraduate qualification in the discipline of nursing until 1973. The school was renamed the School of Advanced Nursing Studies (SANS) in 1970, and the interesting history of its establishment and development over time is outlined by Burgess in her book *Nursing in New Zealand Society* (1984). Anne McDonald described her year as a student at the New Zealand Post Graduate School as ‘chaotic’, as the New Zealand nurse tutors came and went during 1967 as a result of their growing awareness of the need to prepare for the future.

1967 was a chaotic year. Thelma Burton was Acting Principal at the time holding it [the position] for Bea [Salmon] to come back [to] when she finished her Masters. Everyone came and went that year. Elaine Whiteman did all the administration in about the first 2 terms because she was going off on a Commonwealth tour, Elsie Boyd had been in America and came back, Rita [McEwen] came back from Egypt (or Iran) and we had a passing parade of tutors.

(McDonald, 1:1)

This was not unlike the situation in the 1990s with many of the nurse educators required to obtain degree qualifications, and needing to balance their individual needs for study and writing time with the demands of their students.

The Matrons' Association in the 1960s as a group recognised the need for better preparation of the nurse leaders of the day. They wrote to NZNA in 1966, requesting support for overseas study for nurses because of the geographic isolation for many nurses, and the need to bring about a liberalisation of attitudes and to raise the general education status of the nurse (Hospital Matrons' Association, 1966). In 1968, in response to the need to support these potential nurse leaders, NZNA established a Foundation to foster education and research – the Nursing Education and Research Foundation (NERF). Scholarships, research and travel grants, and book grants were made available to encourage and support New Zealand nurses, and many nurses took advantage of this support to enhance their study and practice. NERF supported forums for nurses to present papers about their experiences or research, and these were published to provide a wider audience with the opportunity to see what their colleagues were doing. NERF also supported the establishment of a NERF Travelling Fellow (now known as a Travelling Scholar), bringing out to New Zealand nurse leaders from around the world to share their expertise by conducting seminars and workshops in a number of local centres.

Two particular overseas nurses who visited New Zealand were influential in achieving change in post basic education. In 1965, Professor Alma Reid and then Dr Helen Carpenter in 1970 assisted the efforts of nurses in New Zealand to lobby for university nursing education.

Professor Reid, Director of Nursing at McMasters University, Canada, prepared a report commonly known as 'The Reid Report' financed by the

University Grants Committee on the role of universities in nursing education. Her recommendations included the proposed establishment of a 'basic' degree programme within a university. Dr. Helen Carpenter, in her report (mentioned previously in connection with 'basic' nursing education), also included recommendations referring to proposals facilitating nursing subjects at university level, and the development of a nursing course within a university (Carpenter, 1971, p.5).

The small group of nurses in Wellington, who established the C. L. Bailey Nursing Education Trust, were a significant, influential group. These nurses were aware that previous proposals for university education for nurses had all foundered due to lack of funds. Miller (1984) suggests that with hindsight it is evident that the Bailey Trust played a crucial role in ensuring the establishment of university programmes for nursing in New Zealand. The Trust made a grant of \$12,000 to Victoria University of Wellington and lobbied NERF to grant money to assist both Massey and Victoria University set up a programme if financial assistance was required (Miller, 1984 p.90). This resulted in grants by NERF to both universities.

Anne McDonald was sure that, without the grant from the Bailey Trust, New Zealand university programmes for nurses would not have begun in the 1970s.

That grant was significant...It is reasonable to think that the university programmes would have waited I don't know how long again. There is no doubt about that. It was a nurse led, nurse development.

(McDonald, 1:3)

The efforts to establish university education opportunities in New Zealand have a history of a long struggle despite the best efforts of individual nurses and the profession. International developments in University

education for nurses described in written texts and observed by New Zealand nurses increased our recognition of the value of post basic education to underpin our professional development, and acted as a spur to efforts to establish such programmes in New Zealand.

Funding has always been a barrier to the establishment of nursing programmes in the university setting, and without the effort and commitment of that small group of nurses in Wellington, we may have waited even longer than the 1970s for university education for the R.N.

The 1970s - Programmes at Massey and Victoria Universities begin

In 1973, at the same time that the pilot nursing courses began in the polytechnics to prepare the Registered Comprehensive Nurse, two nursing programmes began at Victoria and Massey Universities for those nurses already registered. Victoria offered three nursing papers towards a Bachelor's degree, while Massey offered a two-year Diploma Programme as well as a Bachelor of Arts with a major in Nursing Studies. Massey offered its programme as an internal as well as a distance learning programme, and nurses from all over New Zealand began to take advantage of the university programmes and to study nursing as a discipline. During this decade nurses approached Otago and Auckland universities to consider undergraduate programmes as well as programmes for the R.N, but neither came to fruition mainly because of funding demands.

The 1970s saw real growth in the educational opportunities for the Registered Nurse. Some nurses were funded by their employer or by the Department of Health to attend post registration programmes offered by the New Zealand Post Graduate School, as well as diploma and degree programmes in nursing at Victoria and Massey universities. During this decade some nurses also continued university education in other

disciplines, such as education, psychology, sociology and business management, which they had begun when the study of nursing as a discipline was not available.

The written and oral texts revealed the great excitement felt by many New Zealand nurses in the 1970s, as more opportunities for advanced educational preparation in the discipline of nursing became a reality. The significance of post registration education for the New Zealand R.N cannot be underestimated. The hard work to bring about change had resulted in two programmes for the R.N leading to Bachelor and Masters degrees in the university setting. In addition, alongside the changes in clinical practice, was the support available to R.Ns through the Advanced Diploma in Nursing offered by several of the polytechnics.

Nurses in New Zealand at last had a variety of opportunities for professional development in educational settings and the choice to advance their knowledge in the discipline of nursing as well as in other academic disciplines.

Changes in the 1980s and 1990s

The 1980s saw continued growth in post registration programmes at both the universities and the polytechnics with an emphasis on clinically based programmes in the latter. Once the three year degree programmes leading to registration became established in the early 1990s, several of the polytechnics chose to provide post registration degree programmes for Registered Nurses who already had a Diploma in Nursing, recognising the prior learning of these students as documented in their portfolios.

In 1999 undergraduate degrees were still offered by Massey University as well as Masters and Doctoral programmes. Victoria University of Wellington had a post graduate school offering Masters and Doctoral programmes for Registered Nurses. In addition two other tertiary

education providers offered postgraduate programmes, e.g. the Auckland Institute of Technology and Otago Polytechnic. Several of the other polytechnics offered a variety of programmes for the Registered Nurse with a clinical focus as well as shortened programmes leading to a Bachelor's degree in Nursing. The University of Otago Medical School (two sites) and the University of Auckland Medical School were involved in the development of a variety of nursing postgraduate options. The Auckland Medical School had also recently appointed two Associate Professors in nursing with a view to establishing an undergraduate programme in the year 2000.

We need to remember the history of nursing education within the tertiary sector is relatively recent in New Zealand, with programmes only available since the mid 1970s that led to registration as a nurse and focusing on student learning needs.

Many nurses prepared in the hospital apprentice system are still in practice, with a large number without any educational qualifications post registration (anecdotal evidence, databases not available). This can result in a cohort of nurses without the attitudes and beliefs to actively respond to the context or to move forward, and to make a positive contribution. Degree programmes leading to registration as a nurse began in the early 1990s alongside promotion of the self-directed learner. The evidence from this study suggests that it takes time to develop a skilled and experienced workforce, and that while education has always led the way to promote professional development, the changes are very recent. For us to influence and contribute to the future the challenge is to continue to develop nurses with ability to actively respond to the context and who will really effect change that makes a positive difference. We need to remember that advanced preparation for the nurse was essential to enable the profession to move forward as illustrated by the written and oral texts in this study.

Major changes in clinical practice

Clinical practice was given notice of the need to change dramatically in the 1970s. With the reduction of the student workforce in the hospital setting and major changes on the expectations of graduates for the Comprehensive programmes, clinical practice followed the changing developments in the education sector. After decades of minimal development the 1970s saw the beginning of the exciting move to bring clinical practice into the centre of nursing professional development and to be recognised as the ‘heart and pivot of nursing’.

The context related to clinical practice includes three sections: the transition from a student apprentice workforce to a qualified R.N workforce; an account of the major changes in the modes of practice and R.N career opportunities over time.

Transition to a qualified workforce

The major impact on nursing in New Zealand during the four decades came with the transition to a qualified workforce. Along with the gradual increase in the number of Registered Nurses providing patient care came the realisation that plans needed to be put in place to provide for staffing needs as students withdrew from the hospital workforce. The women’s movement of the 1960s and 1970s had encouraged women back into the paid workforce and this was certainly applicable to nursing, especially if work was available on a part-time basis.

Career opportunities for nurses in New Zealand followed international patterns and trends with an initial focus on careers in teaching, administration, and community health. If a Registered Nurse wished to advance in her career as a nurse, and to be paid a reasonable salary, the only viable options in the 1960s and 1970s were to move into either nursing administration or nursing education. This was reinforced by the

attitudes of those making the decisions about advanced education – the academic streams were either in administration, education or in community nursing service (public health or district nursing). Programmes with a focus on clinical practice were a long time coming.

Internationally in the 1960s, like in New Zealand, career opportunities were focused on hospital administration, teaching, and the health services (public/community health) [International Labour Organisation (ILO), p.147]. The ILO reported that in most countries it was notable that opportunity for advancement into these three strands were seldom fully utilised. There was a glimmering of recognition of the value of the clinical practice role in the statement outlining factors that might explain the lack of attractiveness to many nurses for applying for positions above the ward sister level. The report included comment about the wish of many nurses to maintain direct contact with patients and the need to encourage this, while at the same time warning that there was also a need for competent nurse administrators.

Good bedside nursing needs to be encouraged and staff nurses should have the possibility of advancing at least in remuneration, within this service grade. Too much emphasis on this however, causes the danger that other equally important factors may be overlooked. The strain of work in high administrative posts together with remuneration and status not commensurate with added responsibility and duties, are factors which deter large numbers of capable, ambitious, and conscientious nurses from applying for higher administrative posts in hospitals.

(ILO, 1960, p.148)

This beginning recognition of the importance of career opportunity in a clinical practice stream was certainly an issue for the New Zealand nurse. As long as nursing care in New Zealand was provided predominantly by

students, a clinical practice career path for the Registered Nurse was not a focus. In the hospital setting this could only be seriously considered once the R.N was the predominant provider of care. Carpenter (1971, p.20) found that in New Zealand in 1970 there was little recognition that patient care was the essence of nursing. While NZNA had sought to focus attention on a clinical stream for the NZRN in the 1970s (NZNA, 1976), it was not until the students began to be withdrawn from the workforce in large numbers, that this became recognised as a possibility by the profession as a whole.

During this period considerable emphasis was placed on orientation and development programmes through departments of 'Inservice Education'. The first inservice education position was established in the hospital nursing service in 1965 (Department of Health, 1986, p 35). As the hospital schools closed, nursing departments of inservice education grew to meet the needs of several groups such as nurses needing to update their skills, 'back to nursing' groups, and for the new graduates from the polytechnics. Those developing the inservice programmes recognised that modes of practice had changed for the former group, and for the latter, there was an additional need for orientation to both the workplace and to the policies of the employing agency, as a matter of survival. The need for an effective inservice education programme was acknowledged by NZNA in the 1980s recognising that "Inservice education must establish itself as a vital force within nursing to maintain and improve standards of professional nursing practice" (NZNA, 1984, p.42).

In New Zealand we were somewhat behind developments in North America, but ahead of the United Kingdom and Australia in moving from a student based workforce. It was however only in the late 1970s and 1980s that consideration of a clinical career structure began in earnest in New Zealand. In an editorial in the *NZNJ*, the NZNA assistant secretary pointed out that adjustments and changes in attitude towards nursing

service must be made if the move of nursing education into the field of general education was to be successful (Burrell, 1974).

Over this period it was increasingly accepted that a real career was possible for the Registered Nurse in clinical practice as well as in nursing education and health administration/management. The Board of Health in its 1974 Report No. 23, *An improved system of nursing services in New Zealand*, included a proposal for a nursing service clinical career structure. When reporting on his experience on the Board of Health Committee, Horne, a hospital administrator, commented on what seemed to him to be wrong with a career structure focusing on administration.

[It seemed wrong] that recognition, promotion and extra salary for a first-class clinical nurse should come about only by taking this nurse away from clinical nursing and placing her behind a desk. I question whether this is in fact placing the interests of the patient paramount and I seriously question that it is in the interests of the nurse herself.

(Horne, 1975, p.26)

In 1978 negotiations of nurses conditions of employment resulted in a small freeing up of the clinical career structure at a senior level, which needed central government approval. A new grade of 'Senior Supervisor' was created and provision established for hospital boards to apply for clinical appointments at that level (Pitts, 1984, p.59).

NZNA had long recognised the importance of the clinical career stream and in the 1970s developed a proposed career pattern for nursing in the three main streams. Teaching, a management career stream, and a clinical career stream each requiring additional formal education (NZNA, 1976). Unfortunately it appeared that nurses in New Zealand as a profession were not yet ready in the 1970s for this development as no response occurred in practice.

International visitors who assisted with advice regarding how to manage the change from hospital based nursing programmes also influenced developments in the 1970s. Mary Richmond, the first recipient of the Dr. D. P. Kennedy Memorial Travelling Fellowship, spent eight weeks in New Zealand in 1974, just as New Zealand was beginning the transfer of nursing education from the hospital schools to the tertiary sector. She came from Canada as did Helen Carpenter and took the opportunity to discuss the changes occurring in nursing education in Canada. During her visit she pointed out how important it was to put in place structures to support the graduates from a new programme (Richmond, 1974). There was a suggestion that it is very easy for new graduates to be socialised into the old established ways. We did not heed this warning and for many years in some areas the polytechnic teaching staff and students struggled with little support from those outside the system, and constantly needed to explain the goals and objectives of the transfer (personal experience).

Professor Margaret Shetland, former Dean of Wayne State University, Detroit, visited New Zealand in 1975 under the NZ–USA Educational Foundation Fullbright Programme. She worked with the Nursing Studies programme at Victoria University of Wellington and generated widespread interest in the subject of nursing standards. It was believed that a move to a more qualified workforce required clear standards as a guide. This was responded to by NZNA with the development of *Standards for Nursing Services (administration)* in 1978 and *Standards for Nursing Practice* in 1981. Dr Luther Christman, who was the 1978 NERF Travelling Scholar, spent time sharing his experience with primary nursing at the time when different modes of practice were being promoted to an increasingly qualified workforce.

The 1980s saw the number of Registered Nurses gradually increasing but it was not until the mid-1980s that they were providing care in greater numbers than the hospital-based students. Qualified staff as a proportion

of nursing staff in general and obstetric hospitals increased from 41.3% in 1975 to 78.8% in 1985 (Department of Health, 1988). At last the NZRN could focus on the real core of nursing, clinical practice.

In a review and statement of policy regarding nursing education in 1984, NZNA restated its commitment to a clinical career stream outlining that

it is imperative that a clinical career stream is established. Educated and highly skilled nurses must be able to stay within the clinical stream and to receive appropriate recognition and financial rewards. The siphoning of senior clinical nurses into areas of administration and education will inevitably continue but there must be as much opportunity for career advancement in the clinical area as there is in other fields.

(NZNA, 1984, p.39).

This time, ten years after the first report suggesting a clinical career path, there was a positive response, the time was right. Many nursing departments in general hospitals developed positions with the titles of 'Nurse Clinician', 'Nurse Consultant' or 'Nurse Specialist', acknowledging the significance of clinical practice. Many employers used the NZNA policy statements on career development as a guide while some changed the titles of Supervisor and Senior Supervisor to Nurse Clinician and Nurse Consultant.

The 1980s were exciting times for nurses and nursing in New Zealand. We saw the development of new clinical specialist positions in a variety of settings. While clinical specialist positions prospered during the 1980s, opportunities for the expert nurse became available in a wide variety of areas. In the early 1980s many clinical nurse experts moved from the hospital services to nursing education to staff the growing nursing education departments in the polytechnics (personal experience). Independent nursing positions developed in the community, experienced

nurses in hospitals and the community began to extend their roles especially in areas of specialisation such as cardiac, renal and orthopaedic settings. Assessment skills became an important component of clinical practice, and nurses debated the meanings of extending or expanding their role in clinical practice.

During this decade additional pressures on the health sector caused a rethink of nurse staffing patterns, and the concept of a qualified workforce. These pressures included the beginning of significant reductions in the levels of government funding for the health sector in the late 1980s, which led to restructuring and downsizing of services. The State Sector Act of 1988 (SSA) introduced a model of general management across the state sector, which included the health sector. While providing an opportunity for many senior and experienced clinical nurses to move from clinical practice into the general management of health services, it depleted the cohort of experienced nurse clinicians. Reductions in health care funding and the system of general service management began to change the face of the health sector, including nursing.

From my personal experience, reading and conversations with colleagues I believe that during the 1980s many nurses lost an opportunity to maintain a strong clinical practice focus as senior clinicians in large numbers moved into nursing education or general management. Some of these expert clinicians had neither the formal qualifications, nor the necessary skills, to support their change of direction into management or education and found the change difficult, and led to some leaving nursing altogether.

While the transition to a qualified workforce took place primarily in the 1970s and 1980s, changes occurred in the career opportunities for the NZRN that reflected this transition. The shift to the R.N as primary care

giver in the acute hospital setting was the trigger to the demand for career opportunities in clinical practice. It seems very strange to me in the 1990s, reflecting back to that period, that we gave so little cognisance to the importance of clinical practice and patient care described by Carpenter (1971). Strange that it took so long to recognise clinical practice as the 'heart and pivot of nursing' and to value the skills and ability of those providing the care.

While the R.N is still the primary provider of care in the 1990s, the decade saw further loss of experienced clinicians in the early 1990s as the effect of health sector restructuring led to redundancies and resignations (Gunn, 1997; White, 1997; Williams, 1993, 1994). Several of the participants in this study perceived that nursing lost a generation of expert clinicians due to the changes, in the late 1980s and 1990s and that we are only now beginning to rebuild (Carroll, 1:12; Lee, 1:5; & Peach, 2:12). This has meant that there has been a shortage of experienced nurses in many acute care settings and in some areas the reintroduction of less qualified personnel. The debate continues regarding the appropriate role of the R.N and other nursing personnel, as well as the role of the nurse specialists, the concept of advanced (or advancing) practice and the competencies required for practice as an R.N (Christensen, 1999; Gunn, 1998; Ministry of Health, 1998; NZNO, 1998; Nursing Council, 1998).

In the late 1990s nurses are consolidating their position in clinical practice as well as taking advantage of using the value of their nursing experience to contribute to the health service in a wide variety of fields. These include positions such as CEO of health service providers, managers in health funding organisations, senior policy analysts in a variety of health agencies, advisors to government departments and directors on Boards of health care providers and other health care agencies.

The replacement of the student 'nurse' (improper use of the title) with the R.N during the 1970s and 1980s was one of the most significant events of the four decades in this study. The ramifications of this change impacted on many sectors of the health and education systems. Hospital schools closed, Departments of Nursing in polytechnics and universities opened, students were no longer the predominant workforce in the hospital service, and the R.Ns gradually came to realise that they had been prepared 'to nurse' and that nursing involved patient care.

While the goal of a qualified workforce in the general hospital setting was almost reached in the late 1980s, structural and financial changes altered the nursing skill mix, and different staffing patterns emerged. The shortage of experienced nurses in the 1990s impacted on the ability of the nurse, individually and within the profession, to grow and develop and be clear about future directions for nurses and nursing.

The next section outlines the changes needed in the provision of nursing care to meet the needs of a qualified workforce.

Development of nursing modes of practice

The 1960s saw speciality areas of nursing care emerging and patients being grouped into areas of like need, such as long-term care units, intensive care units, post-operative recovery rooms (Pitts, 1984). The role of staff and staffing mix became an important subject for debate and study. While the NZRNA Nursing Services Committee carried out studies and actively explored different aspects of nursing leadership, publishing in the *NZNJ* during 1969 a series of articles under the title of 'Nursing Service Forum', there appeared to be little change or impact on the provision of care.

The 1970s, however, was a period of major change for nurses in clinical practice in New Zealand as well as overseas. Chaska (1978), an American

nurse, outlines the causes of what she states are more changes in nursing practice in the 1970s than in any other area of the nursing profession. These include increased emphasis on the prevention of disease; changes in the settings where health care is provided; nursing's progress in defining the uniqueness of the nurse; development of new roles in nursing; increased costs of health care delivery; Government planning in providing health care; attempts by nurses to attain more autonomy in their roles; and increased awareness and expectation of the patient for quality in health care delivery (Chaska, 1978, p.233). Every one of the items she lists was mentioned by the participants in this study as issues in the 1970s and 1980s for the nurse in New Zealand.

While New Zealand nurses travelled overseas to observe and learn from other countries, especially the United Kingdom, Canada, and the United States of America, they recognised that we needed to make decisions that suited our own ways of work. The proposed change to move nursing education from hospital based programmes to the tertiary education sector provided a necessary stimulus to the debate about how we should practice nursing in New Zealand. Modes of clinical practice (Appendix Six) were being read about in overseas nursing journals, experienced by New Zealand nurses visiting other countries, and debated back in New Zealand. Post-registration nursing education programmes all began to introduce teaching related to modes of practice that were more appropriate for a Registered Nurse who could think critically, problem solve, and make appropriate professional judgements. Team nursing, patient assignment, and primary nursing were all seen as appropriate in the new environment of a qualified workforce.

Team nursing was popular in the 1970s as the transition from an apprentice based nursing education to education in the tertiary sector enabled a mix of Registered Nurses and nursing students to form a team responsible for a group of patients. Responsibilities were shared

according to skill and ability. The team would meet once during the duty to discuss patients and their progress. This enhanced the decision-making ability of the team and provided role models for the less experienced.

As Registered Nurses became the predominant providers of care in the hospital setting, other modes of practice were in vogue that built on partnership between the individual patient and the nurse. Over time 'patient allocation' and 'primary nursing' (founded on the philosophy that the patient – not tasks – is central to the focus of the nurse) were introduced along with nursing care plans (more properly called patient care plans). This required the nurse to identify the needs of the patient and to make a nursing diagnosis prior to deciding on the plan of nursing care for the patients' stay. The use of such plans required assessment and analytical skills and the ability to decide on the best approach to meet the needs of different individuals. The 'logically distinct act of thought' Dewey wrote about in 1910 became formalised into a series of steps called problem solving and when applied to nursing was often referred to as the 'nursing process'.

The problem solving process...is a fundamental skill that all nurses must learn. [It] offers a sound basis to effectively practise nursing in the patient's interest in a setting where today's knowledge may be obsolete in a relatively short time. The process also helps in that important task of organising knowledge, for unless knowledge is organised it is not very useful.

(Matherney, 1974, p.vii)

The moves in the 1970s and 1980s to patient assignment and primary nursing were sometimes compromised by the staffing skill mix available – where the lack of experienced nurses and the use of too many casual staff meant that continuity of care was difficult.

In the 1990s a variety of modes of practice were used that take into account variables such as practice setting, the availability and mix of staff, and funding. This sometimes saw tensions between the perceived needs of management to be efficient and cost effective and the perceived needs of nurses for sufficient resources to provide safe quality care.

The changing modes of practice reflect the changes in the nursing context over the four decades. They became really significant in the 1970s with changes in health care settings, increased specialisation of health care, increasing costs, and increased acuity of the patients.

The response of the profession to these changes mirrored the responses to the introduction of social sciences in nursing education and the recognition that care needed to be more individualised to meet the different needs of each patient. As modes of practice were introduced founded on the philosophy that the patient is central to the focus of the nurse, the need for quality assessment and decision-making skills became apparent. Such developments would contribute to the ability of the nurse to be actively responsive to the context, to make a difference and effect change.

The cyclical nature of workforce availability

Any work on modes of practice and career structures for the R.N is impacted upon by the cyclical nature of workforce availability. During the time period under study nurses have voted with their feet when they have perceived conditions and opportunities have not favoured their employment. Shortages and surpluses of nursing staff are part of our history, both internationally and in New Zealand and need to be factored into any discussion on the future of clinical practice.

The cyclical nature of nurses' availability and willingness to work can be linked to many factors including changes in policy, changes in the economy and changes in the socially accepted roles of women.

Using the 1960s as a base line, women all over the world began to develop a greater awareness of the role they could play in society (Horn, 1999; Society for Research on Women in New Zealand, 1966). More married women began to return to work after their children reached school age, mainly in a part-time capacity. Nursing was an ideal occupation for part-time work and many employers used this availability to cover evening and night shifts in the hospital. In New Zealand the 1970s were generally positive for the nursing workforce and most nurses were able to choose their employer and employment preferences. This was associated with the time of the transfer of nursing education from the hospital schools and withdrawal of students from the available workforce.

The 1980s, however, saw examples of the cyclical nature of employment for nurses. In August to November 1983 the *NZNJ* documented in articles, editorials, and letters to the editor issues relating to a nursing surplus. Comment included differing views about whether the new graduate could find work, concern about recruiting staff from overseas when New Zealand nurses could not find work, the shrinking job market, and a request for a subcommittee of the executive to study the employment problems of nurses. Two years later, in 1985 the *NZNJ* was writing about nurse shortages. The April issue mentioned that 80% of hospital boards reported nurse shortages (*NZNJ*, 1985, p.24). The May 1985 issue reported a speech made at the NZNA conference by the then Minister of Health, Dr. Michael Bassett. He commented on the confusion felt by the politicians as they heard differing stories regarding staffing issues.

In the past it seems to have been not much more than inspired guesswork...I am amazed when I look back over the debate on this issue in recent years...My predecessor as Minister of Health in August 1983 said that 'there is no shortage of nurses, but there is a maldistribution of nurses, with special skills, in some areas of the country'...Then in January 1984, I find a press statement from the

NZNA expressing delight that their fears of nurse unemployment had not eventuated, but warning that by the middle of 1984 (which I remember, was only eight months ago), nurses might have a difficult time finding jobs. A surplus of nurses looked to be on the horizon...During the 1984 election campaign nursing shortages were no part of your concerns. In the letters sent out to all parliamentary candidates, they were not even mentioned...I met your full executive as Minister on 11 October 1984. There was no discussion about a nursing shortage at that time...I tell you all this by way of background, because I was frankly amazed at the sudden claims about nursing shortages, which coincided with the wage round negotiations in February.

(Bassett, 1985, p.6)

The Minister did not appreciate the rapidity of changing workforce availability. This period in 1985 also coincided with the end of a period when a wage freeze had been in place and nurses were very dissatisfied that their voices had not been heard. They were voting with their feet.

The October 1985 issue of the *NZNJ* included comment on a recently published report of the nursing manpower planning committee *Nursing workforce planning* which suggested that improving the nursing retention rate was the single most important determinant in workforce planning. The report also stated that there has been no national agreement on the number and categories of nurses required for specific nursing services,

and suggested that it was indeed debatable whether there should be any such agreement (Department of Health, 1985, p.33).

The late 1980s saw the end of national health workforce planning and since that time market forces of supply and demand have been a predominant influence. When different groups claim there is a shortage, without centralised data collection, there is only anecdotal data to support claims. For the first time since the move to staff hospitals with a qualified nursing workforce, questions were being asked about the structure of nursing positions in the public hospitals, the skill mix and financial pressures on the system.

In response to these pressures, increased use of less qualified staff was an option managers considered when filling available positions as well as the use of part time or casual employees or bureau staff (staff employed by an independent organisation to fill casual vacancies). While part time or casual work was sometimes seen as fitting in with the lifestyle of women who do not wish to work full time, it was important to ensure that the balance of full time and part time staff is appropriate for the safety of both the staff and the patients in any one area.

Increasingly pressure on the system began to result in redundancies and non-replacement of both nursing administrative and clinical nursing positions. Several employing agencies restructured more than once causing considerable anxiety for nurses in the hospital sector. Some nurses took this opportunity to move out of the hospital sector into independent (self employed) roles as consultants or nurse practitioners in private practice, while others felt they were victims of a system for which they had been ill prepared.

Koerner (1992, p.2) a nurse administrator visiting from the USA, stated in an editorial in the *NZNJ* that if changes were too radical, two responses were created within the nursing profession. "A victim mentality – which

expends great energy in maintaining the status quo, [or] an opportunistic focus which creatively redesigns the work of nursing as the 'answer to' pressing social problems which are demanding health care reform". Both these opposite responses have certainly been apparent in New Zealand and commented upon by several nurses over the past few years (Kilpatrick, 1989; Kinross, 1988; NZNO, 1995; Williams, 1988, 1993). Attitudes, beliefs, and responses to change are dealt with throughout this thesis, and the appropriate attitudes and beliefs are essential components in ensuring the effectiveness of the nurse, and the ability to move forward.

Nurses are the largest employee group in the health sector and staffing costs are the largest component of the health budget. In times of reductions in health funding, nurses are often seen as a group to target for cost savings. Pressure on hospital budgets continued and in the late 1990s we still saw adjustments being made to find the best balance of staff to meet the standards of nursing care required. Many experienced nurses were frustrated by the seemingly endless changes particularly when nurses perceived these as compromising both standards of care and patient safety (NZNO, 1995). Much of the loss of experienced nursing staff was reported anecdotally as national statistics of years of service were no longer available. This loss of experienced staff put additional pressure on the full time experienced staff who were expected to carry a patient load, act as preceptors and mentors for new graduates and inexperienced staff, as well as co-ordinate the care provided by any casual or bureau staff. NZNO was active in providing guidelines for safe staffing for their members to ensure that they did not put either their employment at risk or risk complaints related to nurse shortages that might threaten their ability to practice from a legal point of view.

The Ministerial Taskforce on Nursing (1998, p.76) stated that one of the major impacts from working in a poorly managed stressful environment is how to retain senior experienced staff, and how to recruit new nurses into

the profession. The taskforce also acknowledged the pressures on the nursing workforce internationally as well as in New Zealand and accepted that the increased use of casual staff “negates accepted professional support and safety measures for all nurses and may affect patient care” (p. 57). The taskforce quoted a report by the New Zealand Health and Disability Commissioner recommending that the ratio of casual to permanent staff should be no more than 30% per ward shift, and in 1999, nursing workforce issues remained a major concern.

Many changes in the health sector over the late 1980s-1990s contributed to the dominant perception of ‘loss of leadership’. These changes include differences in the practice role of the Registered Nurse, the movement of large numbers of experienced nurses from clinical practice to the education sector in the early 1980s and to general management in the late 1980s and early 1990s. The restructuring, re-engineering, downsizing of health service providers and consequent loss of experienced nurse personnel, led to the disillusionment of many experienced nurses, who felt they were undervalued and could no longer make a worthwhile contribution to health care.

The big picture trends and patterns of the changes in clinical practice during the 1960s-1990s as revealed by the written and oral texts have been fascinating. While many nurses have criticised or bemoaned the lack of progress in clinical development in some areas, we need to be reminded that the nurse in New Zealand has a very recent history of a focus on clinical practice with the Registered Nurse as the primary provider of care.

Nursing has made great progress over this time. We have established the R.N firmly as an important provider of care; we have accepted the belief that clinical practice is the heart and pivot of nursing; we have begun to establish clinical career pathways that recognise the value of the nurse; we

have nurse entrepreneurs in many settings. We have the evidence of primacy of the nurse all around us.

While the 1990s in particular saw serious disruption to the goals and aspirations of many individual nurses, and loss of experienced nurses that may take years to rebuild, amazing developments have still occurred when we look for patterns and trends. We should be proud of the progress nurses have made over the four decades, and learn from their experiences to inform our present and possible future so we can ensure the continuation of the primacy of the nurse.

The last section in the context chapter concerns professional regulation, which has impacted on the growth of the profession as a whole.

Nursing regulation

Regulation, credentialling, and standard setting are all terms associated with occupational governance (Styles, 1986). Within our social context nurses in New Zealand are governed by a variety of agents such as – the government through laws (statutory legislation): the self through ethical codes and codes of professional conduct: and the profession through established standards of practice and accreditation. Salvage (1993) suggests that it is self-regulation that can be the vehicle of continuous improvement in nursing practice.

While the goal of external regulation, particularly statutes, is to protect the public, self regulation goes beyond that point ... while statutes tend to define standards (for licensure, for example) at a general or minimal level, self-regulation is used to achieve a continuous improvement in nursing practice for the benefit of society.

Salvage (1993, p.42)

In the increasingly deregulated society in New Zealand, the issue of self regulation is important for all professionals and the nursing profession is currently debating the provision and extent of self-regulation for nurses in New Zealand. The Nursing Council has provided a Code of Conduct for the R.N and standards and guidelines related to competencies. The Ministerial Taskforce on Nursing (1998, p.35) suggested that lack of national enforceable specialist competencies is a barrier to funding and that the Nursing Council should hold any national register. There are many in the profession who consider that such a development focused on the Nursing Council as regulator of advanced specialist practice would hinder options for individual nurses and limit possible future innovative developments in the scope of nursing practice. Key events associated with statutory legislation and self-regulation, both significant to the theme chapter on autonomy and accountability, are outlined in the next section.

Statutory legislation

Section 25 of the Crimes Act (1961) reminds us that ignorance of the law is no excuse – and for health professionals ignorance of the law can result in loss of the right to practise (Burgess, 1993). The most significant legislation affecting nurses and midwives is legislation relating specifically to the profession itself – the current Nurses Act (1977) and consequent amendments and accompanying regulations.

New Zealand does not have a written constitution in a single document but it does have a New Zealand Bill of Rights (1990) and an historical document of special significance to New Zealand, which may be considered part of a constitution, the Treaty of Waitangi. The New Zealand Bill of Rights seeks to protect the individual freedoms of all New Zealand citizens, and the Treaty of Waitangi to establish certain rights for Maori, the indigenous people of New Zealand.

Burgess (1993), in the first edition of her book *A guide to the Law for Nurses and Midwives* lists 31 Acts that influence the practice of the nurse or midwife, and eleven Regulations. Some key legislation has been passed since the publication of the book particularly legislation that has influenced the environment in which the health sector must function, and legislation that enhances the rights of the consumer.

In summarising the first edition, Burgess suggested that while some knowledge and understanding of the law is essential to every health professional the most important factor in avoiding problems with the law was the maintenance of clinical competence – competence through self-regulation

Self-regulation

Self-regulation and self-discipline appear in the literature relating to both the individual nurse and the profession as a whole (Styles, 1986). The profession supports and sets the tone and general standards for the self-regulation and autonomy of its members.

NZNO in their *Building partnerships* (1998) document refer to the preference for professional self-regulation rather than external regulation interpreting the 1998 proposals by the Nursing Council to define and enforce competencies as a refusal to embrace professional regulation.

Self-regulation is preferred as a mechanism for control of post registration practice because: Self-regulation is more likely to result in professional standards which are grounded in the reality of clinical practice and in the need of the patient or client. Self-regulation places nurses in practice at the centre of activity...self-regulation is more in tune with the ethos of professionalism.

(NZNO, 1998, p.6)

The issue of whether the Nursing Council should be at the centre of so called self regulation is contentious. The question of competence to practise has been an ongoing concern related to self-regulation. The profession as a whole condemns the current process of issuing a practising certificate without requiring evidence of ongoing competence. Submissions seeking change to this process led to the Nursing Council, in consultation with the profession as a whole, developing a Code of Conduct for individual nurses to use as a guide to their practice (Nursing Council, 1995).

Additional guidance for self-regulation is provided through ethical codes. ICN developed its first code of ethics in 1953 and a revised version was published in 1973 (ICN, 1973). Styles (1986) comments on the shift to professional autonomy over this period

Analysis of the two codes reveals a shift of emphasis from prescriptive behaviours both personal and professional, to principles of accountability... The nurse-client relationship has replaced the nurse-physician relationship as the centrepiece of the code, indicating the ideal, if not always the fact, of professional autonomy.

Styles (1986, p.13)

While nurses in New Zealand often used the 1883 Florence Nightingale Pledge for nurses at their graduation, it was not until 1953 when ICN prepared an '*International Code of Nursing Ethics*' that other guidelines for professional accountability became available. NZNA used this 1953 Code of Ethics until it developed its own code in 1988. NZNO revised its Code of Ethics in 1995 and had input into the Nursing Council Code of Conduct for Nurses and Midwives. As part of its professional activities NZNO also regularly updates its policies including the NZNO Social

Policy statement, and reviews documentation pertaining to Standards for Nursing Practice and Nursing Education.

NZNO has led the profession in the certification of individual nurses as Nurse Clinicians and Nurse Consultants and in 1997 developed, in partnership with the Practice Nurse Section, a pilot NZNO Practice Nurses Accreditation programme (NZNO, 1997). In 1998 the Practice Nurse Accreditation Board accredited nurses for the first time.

In New Zealand the regulatory setting for nurses and nursing is currently a balance of statutory legislation and self-regulation. An awareness of the boundaries of professional regulation is important to any profession and to the growth of individual professionhood.

Nursing organisations in New Zealand

While individuals have made many of the decisions that have influenced nurses and nursing in New Zealand, the profession as a whole has also been influential. The profession has usually been led by individuals or groups of individuals within an organisation. The organisation has then been influential in leading the response to move nurses and nursing forward.

Nursing organisations in New Zealand have made significant impacts promoting nurses and nursing over time, and have waxed and waned in their importance over the decades, as they were created to meet the different needs of the day. The International Council of Nurses suggests that there are three functional pillars that support and promote nurses and nursing, and that national nurses' organisations are established to provide one or more of these pillars - the professional pillar, the socio-economic pillar, and the regulatory pillar. National nurses associations are usually found to be combinations of these three functions, with the common features being linked to the functions of a professional association.

The most frequent models include: professional association and regulatory body: professional association and regulatory responsibilities for continuing and post-basic education and qualifications; professional association with programmes also focused on members' individual interests and concerns; professional association and SEW [Socio-economic welfare] organisation (negotiating body).

(ICN, 1995, p. 97)

New Zealand has nursing organisations that support the three pillars identified by ICN, each developed to meet the needs of the day and to promote nurses and nursing. I have chosen to describe two organisations that I believe have been significant during the time period of this study: NZNO, and the Nursing Council. I will briefly mention other organisations that have impacted on nurses and nursing more recently.

NZNO

The New Zealand Nurses Organisation established in 1909, is the oldest and the largest nursing organisation in New Zealand and has both a professional leadership function, and an industrial and socio-economic welfare focus (for name changes over time refer to Appendix Three).

Throughout its history there has been a tension between the professional and socio-economic functions (Burgess, 1984; Carey, 1984; ICN, 1995; McDonald, 1993; NZTNA, 1909; Williams, 1989). Some nurses perceive that it is possible to separate out these two functions, while others suggest that to neglect one is to neglect the other. Burgess (1984) writes of the need for vigilance in keeping both roles in balance, and of finding ways to develop harmoniously the roles and activities associated with these two differing functions. In 1991 the April issue of the *NZNJ* published a two-page spread, titled 'Being professional', in an effort to respond to criticism from members that the organisation was 'too industrially

focused'. In 1993 NZNA requested ICN to facilitate an open discussion among its members of the professional and socio-economic responsibilities of National Nurses Associations (ICN, 1993).

NZNO has both influenced and/or documented the major changes affecting nurses and nursing from its beginnings in 1909 and left a legacy of these changes in the official record *The New Zealand Nursing Journal* (refer to Appendix Four, for changes to the title of the *NZNJ* over time). The history of the organisation's first 75 years is well documented in the book *Objects and outcomes: New Zealand Nurses Association 1909-1983*. Relevant to this study are the key changes from the 1960s to the late 1990s. These include relationships with other organisations, and changes in national influence and focus.

In the 1960s the New Zealand Registered Nurses Association (NZRNA) was an organisation with strong links to both the regulatory body – the Nurses and Midwives Board, and the Government through the Nursing Division of the Department of Health. Indeed senior nurse leaders held key positions in more than one of these organisations. For example Flora Cameron as Director Division of Nursing in the Department of Health was also the Registrar of the Nurses and Midwives Board. Nurse Advisers in the Division of nursing often held key positions on policy committees of the NZRNA. The Association sought to inform, influence, and lead during this time especially with editorials in the *New Zealand Nursing Journal*. NZRNA also took steps to develop a more effective method of negotiating conditions of employment to meet the demands of the membership.

In the 1970s the servicing of members needs gained more momentum. The Association (renamed the New Zealand Nurses Association – NZNA in 1971), increasingly undertook the representation of individual nurses in the public sector, established staff positions in regions, and established an industrial union for nurses in the private sector in 1973 (The New Zealand

Nurses Industrial Union of Workers – NZNU). The Student Nurses Association amalgamated with NZNA in 1976, and the structure of the organisation and the need for members' input to decision-making continued to be debated. Membership of branches was still mainly senior administrators and nurse educators along with 'non practising' nurses and the question of involvement of the 'bedside nurse' especially the newly Registered Nurse was a matter of continuing concern.

The 1970s and 1980s saw the separation of formal links between the Division of Nursing and the Nurses and Midwives Board, with the formation of the Nursing Council of New Zealand in 1971. This was associated with an increased awareness of the need to decrease the number of departmental nurse representatives on the education and nursing service committees of NZNA (Kinross, 1984).

NZNA continued to grow and represent its members in a variety of ways, with the focus on standards and ethics supporting the practising nurse. The wage freeze in the early 1980s resulted in a very successful 'Nurses are worth more campaign' where nurses in practice took control of their affairs to increase their recognition as valuable contributors to the health of New Zealanders. The NZNU representing nurses in the private sector, withdrew from the umbrella organisation NZNA in 1987, to enable them to employ staff with a focus solely on the private sector.

The latter part of the decade was a tumultuous one politically especially with the introduction of the State Sector Act (1988) and the subsequent introduction of the concept of general management in the health sector. NZNA joined the newly formed New Zealand Council of Trade Unions (NZCTU) – an amalgamation of the Federation of Labour and the Combined State Unions in 1988. The NZNA executive realised that the new environment meant new ways of work were needed, and a major restructuring of NZNA began with a move from NZNA representation

through branches to individual membership of NZNA, and a focus on workplace activities. This restructuring was seen by NZNA as better representing the majority of its members – those working in hospitals and the community as primary care givers.

The 1990s saw the pace of change increase and NZNA changed its name yet again – when it rejoined with NZNU in 1993. The newly amalgamated organisation known as the New Zealand Nurses Organisation (NZNO) was formed to strengthen nurses representation following the introduction of the Employment Contracts Act (ECA) in 1991, which changed the relationships and processes associated with the negotiation of employment conditions. The structures put in place during the organisation's restructuring in the late 1980s enabled NZNA to feel more able to handle the move from national to local negotiations, following the introduction of the ECA. The change was not without its stressors, however, with tension between NZNA and Chief Nurses, and a series of nurses' strikes occurring during the early 1990s, as the employer and employee parties adjusted to new ways of relating to each other. During this period the *NZNJ* published many letters and articles highlighting that many NZNA/O members felt undervalued and betrayed by the policies introduced by various health providers.

This decade also saw much criticism of NZNO by nurses, including its members. Such criticisms include perceived lack of leadership, a focus on industrial issues to the detriment of professional development, lack of ability to work alongside other nursing/nurses organisations and lack of consultation on issues of importance to the profession. The diversity of nurses and nursing, the introduction of new roles and responsibilities, and the challenge of an ever-changing environment, meant that any nursing organisation was facing constant change. The question was whether the crisis associated with change was seen as a danger or an opportunity – and whether the organisation saw itself as the victim of events or accountable

and responsible for the choices it made in response to those events. In difficult times and in different contexts there will always be a variety of viewpoints. There is not necessarily a right or wrong opinion, but to function effectively in such times leaders in organisations need to be clear about their purpose and committed to act in ways that support their values and vision for the future, and this will assist promote and support nurses and nursing.

The Nursing Council of New Zealand

The Nursing Council (hereafter called the 'Council' in this section of the study) is the regulatory body for the New Zealand nursing profession. It is responsible for the maintenance of a register and roll of nurses, for standards of registration and enrolment, and the exercising of disciplinary powers relating to the actions of nurses which may put the public at risk. In 1925 the Nurses and Midwives Act was passed which created the forerunner of the present Council. The Nurses and Midwives Board became responsible for the registration of nurses and midwives.

Anne McDonald talked about the Healey Report, internal to the Department of Health, which was commissioned to look at how the Division of Nursing could be restructured. The authors suggested that

the Nurses and Midwives Board was an albatross around the neck of the Health Department and needed to be separated...Two and a half nurse advisers in the Department of Health did Nurses and Midwives Board work.

(McDonald, 1:1)

Anne also described how until the restructuring this relationship was difficult legally. The Director Division of Nursing would, in her position as the Registrar of the Nurses and Midwives Board, write letters to herself requesting action or opinion. In 1971 the decision to separate the Board

registration work from the work of the Division of Nursing was accomplished when the 1971 Nurses Act created a new autonomous organisation, the Nursing Council of New Zealand (Burgess, 1984).

The purpose of this new organisation was “To protect the people of New Zealand by setting and enforcing minimum standards of nursing education and practice to ensure that those whose names are entered in its register meet these standards” (Nursing Council, 1973, p.5).

In 1977 a major review of the Act was necessary to take into account the changes in nursing education as a result of the development of nursing courses in the polytechnics. Subsequent amendments have provided ad hoc changes to the legislation and in 1999 nurses are still functioning under the major requirements of this outdated 1977 Act. This is despite government promises to review the legislation, and pressure from the nursing profession for urgent change.

In the 1980s the Council addressed a number of issues. These included the critical situation relating to the standards of tutor qualifications (1980), the problems associated with availability of clinical experience where hospital and polytechnics were running their courses and programmes simultaneously (1981), developing standards and audit tools for the Registered Comprehensive Nurse (1986), and refining systems and processes related to the State examinations (1989).

The 1990s have seen the Council develop its first strategic plan, and do some internal restructuring. In consultation with the wider profession the Council developed a Code of Practice for Nurses and took the first steps to prepare for the inclusion of competencies to be met prior to the issue of a practising certificate. The Council has also taken a lead in providing meetings for nurses to debate issues of concern and to provide the Council with opinion to assist in its decision-making. The process of auditing individual schools of nursing is being re-examined, and much work has

been done to promote the concepts of cultural safety in both education and practice.

Other groups

During its long history the NZNA has endeavoured to meet the diverse needs of all nurses and midwives. This was achieved with varying degrees of success and in the 1970s and 1980s as the health and education systems restructured new nursing groups with common interests developed. The Nurses Society developed in the 1970s related to student unrest and dissatisfaction with the service provided by NZNA, particularly in Auckland. The College of Midwives in the late 1980s formed from a special interest section of NZNA, as Midwives perceived the need to focus particularly on concerns related to the practice of midwifery rather than nursing or the nurse/midwife. The NZNA nurse educators section dwindled in numbers as the hospital schools closed and in the 1980s nurse educators in the tertiary sector, both at universities and the polytechnics, formed a new group (Nurse Educators in the Tertiary Sector - NETS) to provide the Heads of Departments of Nursing and Midwifery an opportunity to share issues relevant to nursing/midwifery education and to focus on the rapid changes in their sector. The National Council of Maori Nurses also became an important force in the 1980s seeking to assist Maori improve their health status. As the health sector restructured, the Principal Nurses, later known as Directors of Nursing, felt the need for mutual support. These nurse leaders took the opportunity to take a leadership role in the development of the profession, and building on the previous work of the Principal Nurses Association, formed the Nurse Executives of New Zealand in the 1990s. The College of Nurses Aotearoa (NZ) Inc. was established in 1991 in response to the perception that NZNA was unable to address the professional needs of nurses in a changing health context.

Within NZNA from the 1970s onwards, groups of nurses with similar interest in a defined area of nursing practice (such as nurses interested in education, nursing research, practice nursing, peri-operative care nursing) developed 'special interest' groups. Many of these still exist providing an opportunity for nurses to collectively learn from each other and keep up to date with trends. It is clear from our history that nurses have formed collective groups to meet their needs over time. Such groups wax and wane in their significance and contribution to the profession as they strive to meet the diverse needs of changing times.

The context chapter is the beginning of the account explored in this thesis. It helps develop an understanding of the context on which the theme chapters build. While the premise of this thesis is that it is nurses who make a difference and effect change, nurses with particular attitudes and beliefs that can be actively responsive, this always takes place in a particular context.

In listening to and analysing the oral histories, as well as exploring the written texts it was clear that there were often particular individuals associated with important events. Key people with a vision of what needed to be done, making decisions. This also applied to the profession as a whole. When the profession wanted things to happen, it would pull key people together and use their best ideas to move ahead.

This context chapter is a descriptive synthesis of the important events I came to understand from the source material. The major transitions noted were national 'big picture' events with some reference to international trends. By understanding these big events in nursing education, practice, and regulation, I could talk about nurses and their attitudes, beliefs and responses within the context, both within and under the events, and illustrate how nurses have responded to changing times and major shifts in developments within the profession. For example I could explore through

the experiences of those who were there, what it really meant to start a new school in a polytechnic (*Shadbolt, 2:7*), or introduce a new mode of nursing practice to a sceptical and unprepared workforce (*Mathias, 1:2*).

With this awareness in mind it is now important to explore the question of the ‘why’ and the ‘how’ of these changes. Why and how they evolved and how they were shaped and influenced by nurses.

Chapter Four: Nurses' decision- making: changes over time

I have encouraged nurses everywhere to...think of a world in which the words of Florence Nightingale “No system can endure that does not march” resound throughout our daily lives.

(Styles, 1985)

Nurses' decision-making ability is the first step in the process that will ensure that nurses 'march', and that nurses move forward reinforcing the primacy of the nurse. My position regarding this theme is very clear. The process of decision-making has changed over time and is continuing to change. Decisions nurses have (or have not) made in the past have had a major influence. The structure and function of decision-making has been modified over time, enabling the development of the ability to utilise professional judgement to make effective decisions. This ability to make effective decisions has made a difference to how both the R.N and the nursing profession has grown.

The powerful influence of the nurse is showcased using content areas that emerged from exploring the source material and processing the material through four contrasts. The four content areas are shown in Figure Four (redrawn on the next page) and these new understandings are made more explicit as the chapter develops.

After a brief overview of how I have used the term – 'what is decision-making', I move to a discussion of the importance of the first content area, the effect of an evolving environment on nurses' decision-making. This is followed by an overview of the changing patterns of decision-making

over the four decades. The major sections outline the last two content areas - changing attitudes and beliefs associated with decision-making, and the responses of the individual nurse and the profession to those changing attitudes and beliefs.

Figure Four:

The first two content areas describe the ‘what’ of decision-making – a synoptic descriptive synthesised account of the key ideas that emerged for the oral and written texts. The third and fourth content areas offer a different view – a very personal perspective provided by the participants. The revelation that the participants learned that they could make decisions, how they learned to do that, and the realisation that others could learn too. The understanding that we can teach others and support and assist others to learn, and how we could move forward individually

and professionally. The chapter concludes with a synopsis of the whole, by using the perspective of two individuals, two participant vignettes. Through this exploration we can gain a deeper understanding of some of the events and the personal attitudes beliefs and responses that Lee Mathias and Margaret Bazley shared as they explored the what, how, and why of decision-making over time. They shared their insights into the importance of decision-making in relation to the primacy of the nurse.

What is decision-making?

Decision-making is concerned with the power and/or authority to make decisions – the legitimate power to fulfil a charge. The nursing literature addressing the issue of decision-making in nursing uses a number of terms commonly and interchangeably. These include decision-making, clinical judgement, clinical inferences, diagnostic reasoning, intuition, professional judgement and problem solving (Benner, & Tanner, 1987; Benner, Tanner, & Chelsa, 1996; Doubilet & McNeil 1988; Grier, 1976; Jones, 1988; Offredy, 1998; Tanner, Padrick, Westfall, & Putzier, 1987).

Some of these terms refer to the process of how decisions are made; the stages and strategies used by nurses during the process of coming to a decision, while others denote the outcome of such a process; and the factors influencing the decision-making process.

In this study the term decision-making is used to encompass the process involved taking into account the problem or task. The focus will be on nursing decision-making being about making judgements, and being responsive to situations relating to the work of the nurse. The process of decision-making is always open to environmental influences, and some of these are outlined in the next section.

The effect of an evolving environment on decision-making over time

The first content area, an evolving environment of decision-making over time was influenced by a number of factors relating to the perceived needs of the time period. This section describes the ‘big picture’ of these perceived needs 1960s-1990s, outlining the environmental influences, what kind of decision-making occurred, and what support provided for students of nursing and R.Ns of the day. It enables the reader to put the primacy of the nurses in context.

The 1960s

In the 1960s when the ‘nursing’ workforce was mainly students of nursing, the perceived needs influencing decision-making included concerns for the safety of the patients and the need for a sense of security for the students. The environment was influenced by a bureaucratic hierarchical structure, the dominance of rules and regulations, the use of protocols and procedure books, task or functional nursing as the predominant mode of practice, and failure within the classroom to integrate nursing theory with clinical practice.

The predominance of unquestioning conformity and the following of rules and protocols marked decision-making by the students. Learning support for students was mainly through discussion with peers, after duty in the nurses’ home. While some R.Ns supported students they were not available 24 hours a day, and there was little clinical support provided by the nurse teachers from schools of nursing.

The long history of nursing, nationally and internationally, has links to both the church and the military (Miller, 1980; Salmon, 1974). The church influence highlighting a sense of service, leading to the ‘mother, saint or servant’ image of the nurse, so widely written about in nursing in New

Zealand and internationally (Bickley, 1983; Jones 1988; Kinross N., Chick, N., Thomson, M., & Pybus, M., 1976; Perry, 1987) with the army requiring unquestioned discipline from its members, observance of a clear hierarchy of authority, and the strict following of sets of rules and regulations (Muff, 1982). The descriptive language of titles, and uniform as identification, reinforced these links.

Madjar, a New Zealand academic, proposed that the strongest emphasis during the Nightingale era was on 'nursing as discipline', i.e. the conforming to rules and regulations.

[This is seen] reflected in the values and organisation of nurse training, the hierarchical relationships in the workplace, the strict code of ethics and rules governing personal behaviour, as well as the stress on a tidy, organised uncluttered environment. The delegation of medical tasks required that nurses carried out observation and interventions in a disciplined fashion, in strict accordance with instructions given to them by those in authority.

(Madjar, 1987, p.1)

This was still the case in the 1960s and 1970s in New Zealand and the hierarchical nature of nursing in New Zealand was very similar to that in the United Kingdom and Australia. In the 1960s the Director of Nursing in the Department of Health, Flora Cameron wrote of her concerns about the unquestioning following of rules and rituals in hospitals, commenting that a great deal of ritual became established within nursing practice and that "many procedures and routines have become an end in themselves" (Cameron, 1963, p.12). The need to question some of the 'old ways' was suggested by some individual nurses (Cameron, 1963; Burrell, 1974), with Margaret Chambers (1960, p.4) seeking "to provoke nurses to find their voices" in her presidential address to the NZNA conference in 1960.

A nurse from the United Kingdom around the same period illustrates, however, how such questioning when it did occur could still be seen as a problem. On receipt of her first ward report, a student was just leaving when her ward sister whom she profoundly admired called her back with these words. “Just one word of advice nurse, as you go through the hospital, please, for your own sake, do not ask so many awkward questions” (Cox, 1993, p.162).

This constant repetition of tasks did not necessarily enhance the learning opportunities of the students.

As I look back on my own training, I think we must have had a flock of angels hovering over us protecting us from our own ignorance. I knew how to give fifteen children intramuscular injections in the shortest possible time, but I did not know how to observe the effects hospitalisation was having on those children.

(Gilbert, 1981, p. 178)

Strict routines were established and the procedures were predictable in their timing day after day. For example patients were all washed in the early morning – often being woken for their bed sponge. Bedpans were offered as routine after meals whether patients needed them or not. Clear policies, rules and regulations meant that decisions were made to conform to standardised processes and procedures without the need to question or refer to others. The *NZNJ* in 1959 and 1960 published a “Revision of standards of nursing techniques as recommended for use in New Zealand Nurse training schools...undertaken by members of the National Florence Nightingale Committee of the NZRNA during 1958”. The revised techniques were circulated to all Matrons of training schools and began to be published in the *NZNJ* in August 1959. They included details of such ‘techniques’ as handwashing, the use of masks, irrigation of the ear/eye,

urine testing, sterilisation, care of the hair, observation of patients and reporting on their conditions, and meal service.

While there was concern at the unthinking/unquestioning following of rules and rituals, there was recognition that a workforce of students comprised some risk to the public. Following clear rules and policies provided a safety net for the patients and additionally a defence against anxiety for the students.

Menzies (1970, p.141) suggests that the picture of the general student nurse following the bureaucratic rules and regulations can be seen as a “major defence system against anxieties experienced as a result of the nature of their work.” Minimising the number of decisions to be made through these rules and regulations was thought by some to provide a safer and more secure environment for the patient, and a number of the oral history participants commented on the need for rules in this time period.

Margaret Bazley said that it was the rules that really stood out for her in her general training – much more so than in the psychiatric area.

There was a rule for everything and you did it according to the rules. I thought in later years that...because there was a rule for everything and you just did as you were told and you didn't question anything – you didn't think...it gave a level of safety that went out the window when we allowed people to think. I thought in later years that when the error rate in medication that we had in both psychiatric and general hospitals occurred, this would never have happened in those days, when everything was just laid down – but it had to be, if you were going to use student or untrained labour. The only way you were going to have any safety was with rigid rules and controls.

(Bazley, 1:1)

Mia Carroll also suggested that there was indeed some security associated with the hierarchy and control.

There was certainly great clarity about what you did – your role was very clear. If you were ‘on bedpans’ that was your role. If you were on ‘sputum rounds’ that was your role – the task allocation of care was immense, but the role modelling was also immense. It is hard for me not to reflect back on those times, and reflect on what the impact is on current practice [of not having the role modelling]. You didn’t leverage information in any meaningful way – you just did the tasks, and I never interpreted the data that I recorded, or very seldom. Maybe in the second or third year – yes in the third year I did. I certainly remember interpreting people’s pain and interpreting observations to be meaningful and was listened to. We had huge responsibility – early – and one which we took to without question – probably very naively when I reflect back.

(Carroll, 1:4)

Stevenson (1997), a New Zealand nurse, who undertook an historical study about nursing in general hospitals 1945 – 1960, commenting on nurse decision-making during this period states that knowing how, but not necessarily why, led to a system where nurses were not encouraged to question, or to think, but to do.

Alongside the use of rules and clear expectations of a ‘disciplined workforce’, hospitals in the 1960s were also perceived as fairly typical of traditional bureaucratic organisations (Etzioni, 1969; Miller, 1980). The New Zealand nursing hierarchy in a hospital in the 1960s consisted of Matrons and their deputies, supervisors and their deputies, ward sisters and their deputies, with the centrality of decision-making and the power for making decisions at the top of the organisation. Moulson (1984, p.99),

a New Zealand nurse administrator, wrote about the effect of the bureaucracy on the profession from her perspective as a Principal Nurse in a psychiatric hospital. She titled her paper *Trained incapacity – a bureaucratic dysfunction that can be a professional deformation*, and described how with centralised decision-making it is very difficult for those lower in the hierarchy to gain experience in participating in decisions or to be close enough to the environmental input to make decisions that are informed and rational. While limited decision-making is written about extensively in the nursing literature, Boston and Winteringham (1999) in a political broadcast suggested that centralised decision-making and limited autonomy was a common feature of New Zealand society especially in the public service until the mid to late 1980s.

The written texts particularly revealed the sense of strict discipline, and the hierarchy in nursing, was reflected in the terminology used over this time. ‘Allocation of duties’ according to seniority; ‘rosters of days of work’; ‘titles’ – such as ‘senior’ and ‘junior’ nurses, ‘supervisors, ward sisters and charge nurses’; ‘reference procedure books and manuals’ ‘the teaching of standard techniques regardless of the patients needs’. Many student nurses were ‘trained’ to be obedient, to follow instruction from their ‘superiors’ (sometimes with only a few months more experience) without question, to speak to senior staff with hands behind their backs and seeking permission to speak, to stand when a senior nurse or doctor entered the room, and discouraged from asking the ‘why’ question.

Substantial evidence that this was a national phenomenon exists in class notes, NERF oral history tapes, journals, and texts outlining nursing at the time (Brown, Masters & Smith 1994; Lovell, 1989; McDonald, 1993; Russell, 1990; Silverson, 1995).

Another hierarchical influence on decision-making in the 1960s was the ‘pecking order’. The student nurses providing nursing care in hospitals

were predominantly young unmarried women supervised by the experienced ward sister – older unmarried women. While the training provided was sometimes described as an ‘apprentice type training’ it was not so in the sense of implying an apprentice who learnt from an experienced practitioner. Experienced Registered Nurses were few in number on each ward and sometimes on afternoon and evening duties there were no Registered Nurses on the unit – just a Supervisor ‘on call’. The students were primarily hospital employees providing a service (patient care) working six days a week performing tasks from lists outlining their responsibilities for the day. The most experienced student on a particular shift or duty (perhaps in their third year) would complete the most complex tasks allocated to students, and the least experienced (perhaps in their first year) would complete the simplest and most repetitious tasks. Sharing her experience of this system, Smith (1988) writes about the ‘pecking order’ as follows

We admired and feared our sisters, those who had earned their five-pointed stars and veils...Staff nurses were usually less awe-inspiring than sisters. Their own training days were only months or a year behind, and they could still recall the agonies and fears of those times. They relieved the Sister on her day off and did mysterious things with bloods, drugs, and flowers...The senior nurse on each duty had the most exciting and responsible tasks...We admired our seniors greatly for their skill with forceps, clip-removers, catheters, syringes and needles, and drips. Most seniors, with memories of their junior days still close to them, were not above stooping to carry a bedpan or help with paper work so that we could all go off duty. The middle nurse did all the jobs too lowly for the seniors or too complicated for the juniors...The junior nurse in a training hospital was the lowest form of life.

(Smith, 1988, pp. 6-7)

The discipline, rules, and regulations associated with the hierarchical nature of nursing were for some a safety net, while for others a frustration. For some it meant security, while for others it meant complex changing expectations when the 'pecking order' didn't work. The remarkable thing to note is, however, that some nurses continued to learn to make independent decisions, to seize the initiative and to effect change despite the restrictive hierarchical environment.

The failure to meaningfully link nursing theory and clinical practice was another important environmental influence impacting on decision-making ability. Hospital priorities were to meet the needs of the sick, which meant that the value of linking theory and practice for the student nurse were not a priority.

In the beginning of each of the oral history interviews the participants were asked to briefly outline their nursing careers. Several who were students before or in the early 1960s and 1970s spoke of their 'training'. The way the institutions planned to meet their staffing needs without concern for the integration of theory and practice. While this meant that those lists of tasks and the hierarchical nature of practice helped the students plan their day, and gave some sense of security, it was also a source of considerable frustration. *"As student nurses we often wondered why we went to school at all. It didn't seem to have any relevance"* (Keith, 1:2).

For example, the students could be attending a block of lectures related to caring for people with eye disorders, while they were working in an orthopaedic ward, and they may have had no theory underpinning their role in the orthopaedic area. This seriously undermined their ability to begin to develop critical thinking skills needed for effective decision-making.

Mia Carroll described the fairly typical disjointed nature of the hospital programme for her in the early 1970s, which was similar to the 1960s.

[I was] doing ear, nose and throat theory and working in an acute medical ward and I hadn't covered myocardial infarction. [The most common reason for admission] – but I knew about ears! The disjointed nature of theory and practice was very real.

(Carroll, 1:2)

Similarly McCoppin and Gardener (1994) two Australian nurse academics suggest that the hospital based system of education in Australia had left the student nurse “torn between her education needs and the more urgent demands of her job as an essential member of the hospital workforce”. They quote a report that in the opinion of New South Wales Matrons’ Institute in 1967 this system of education resulted in a nurse who was

restricted in outlook, resistant to change, and unable to cope confidently with the scientific and technical advances in medicine and the social problems of nurses.

(McCoppin & Gardner, 1994, p.29)

This mirrored the situation in much of New Zealand in the 1960s and 1970s. As patient acuity increased students of nursing expressed concerns about the pressures of needing to make decisions they felt unprepared to make. Elizabeth Lee talked about how being put in a position of responsibility beyond your capacity at the time was very stressful, and needed you to think through your actions very carefully.

One example that I can remember was a second year student sent to the elderly peoples ward and she was the senior nurse on and of course at that stage you did the drugs...normally a third year student nurses responsibility so it wasn't something that we had had done very much of. She had to give out digoxin and the bottle had run out. So she borrowed from somewhere else and it came in a little brown envelope with digoxin 0.25 on it. It had 10 or 12 [tablets] in it and she gave the patient the whole lot and we were just so shocked by this. How could a person not sort of think through that, but then that situation she'd been put in was unusual – beyond what was normally expected of her too and so looking back on it now, we had a lot of those situations at that time.

(Lee, 1:6)

In 1972, a student nurse described the pressures students were under in a prize-winning essay published in the *NZNJ*.

I am convinced that a great number of these young people leave nursing because they feel themselves unprepared to bear the responsibilities thrust upon their ignorant heads. Far too soon in her training the student nurse is expected to give care and make decisions far in excess of her knowledge. She is expected with often a minimum of sketchy explanation – or none at all - to nurse patients' suffering from conditions of which she may never have heard. She "specials" patients often totally incapacitated and dependent, whose lives may depend upon the efficient functioning of equipment, the use of which is a mystery to her.

She is often in charge of even more junior terrified nurses in busy wards with critically ill patients whose condition may at any moment deteriorate subtly or dramatically...Often the student copes. She scurries and muddles and worries through her work, frets about her mistakes while off duty and returns apprehensively to the fray the next day. After several months of this she may be honed down to make a very fine responsible, efficient nurse, albeit somewhat harassed – if she survives. But she may not survive.

(Stewart, 1972, p.23)

This concern for survival was expressed in the high attrition rates for students of nursing during the 1960s, and for many students what made the difference was the support offered by their peers. Because of transport, safety and security issues, and the need to be 'on hand' with split shifts or early morning shifts, hospital boards continued to provide accommodation for student nurses in the grounds or close by the hospital – the 'nurses home'. This had an unexpected socialising/debriefing function, providing support for the students as they shared their experiences when they came off duty. Sharing experiences in the nurses' home was in many situations the major way students were supported and how they learned to link theory and practice. Talking about their work certainly provided support for each other when they didn't know how to handle a situation, when they were physically and/or emotionally exhausted, when patients they were fond of died, or when senior staff made life difficult. Yvonne Shadbolt in discussing how individual nurses made their decisions, talked about the learning that went on in the nurses home, the debriefing, and the reflection that occurred.

In the 'olden days' when people lived in staff residences, Nurses Homes and so on - there was a fairly unconscious but certainly an ever present process that went on. After evening duty you went back to the Nurses Home into the sitting room.

You had your cocoa and toast and peanut butter or whatever – it was 11 p.m. You talked about what had happened and you told people what worried you and they told you that you'd done the right thing or what you should have done instead –and all those sorts of things. There was an opportunity for a kind of peer review, if not review at least support, and affirmation that perhaps was not present later. A primary support system dissolved without conscious, planned replacement.

(Shadbolt, 2:4)

This sense of the need for support was reflected in the many ways students assisted each other. I remember in the 1960s when students changed to a new ward they often left lists for the new students about the routines to be followed, the idiosyncrasies of the ward sister, or senior medical staff, or of some of the long stay patients.

'Living in' however could also be yet another experience of 'command and control' (Stevenson 1997). While many student nurses had come nursing to get away from what they saw as restrictive parents or from small country towns to the big city (stories of many of my peers), life in the nurses home did not take into account the fact that many of these young students (mostly young women) were well educated young adults. They were given responsibility for patients well being on the one hand, while on the other hand they were expected to conform to restrictions and rules even governing their time off duty. Some parents expected that the 'home sister' and her assistants would act as 'guardians for their children'. The students rooms in the nurses home were regularly inspected for tidiness, approvals required for 'living out' on days off, and limitations placed on the number of times the students could go out at night and how late they could stay out.

It seems extraordinary today that 20 year olds considered adult enough to run a ward when sister is off duty, dish out drugs, and make life affecting decisions, were not trusted to be out after a certain time. [Whether this was] meant to ensure adequate sleep, or to preserve our maidenly chastity we were uncertain.

(Smith, 1988, p.20)

Such experiences and demands to conform did nothing to foster an independence of thought or to develop individual skills in making decisions. Sally Shaw commented that one of the paradoxes she considered interesting was the fact that with many nurses growing up in fairly regulated environments we still developed those willing to be different.

Many of us in my generation grew up in fairly regulated environments both within the family, at school, at boarding school and again when we went into nursing...New Zealand society was fairly regulated in many ways rules and doing the right thing and social mores were always important. Within that environment, its

pretty amazing really that everybody just didn't emerge a passive person and that people did make decisions. I think that part of it is maybe [there is] always, with some people, a certain spirit of rebellion, if that's the right word, against these rules and regulations and confines, and therefore wanting to do something in a different way, weighing up the consequences in your mind and making a decision about whether you're going to conform or not conform and that's been the pattern for many nurses at that period of time. [1960s – 1970s] The whole process of what many people went through was stepping 'outside the box' from a very early age.

(Shaw, 2:2)

Some New Zealand nurse leaders of the day wanted student nurses to think for themselves, to question their practice, and expressed concern that this was unlikely to happen while students were hospital employees and lived in nurses homes with the restrictive approach to the students personal lives.

While this decade was marked by hierarchical bureaucratic structures, tightly controlled processes, and little opportunity to learn to function independently, many individual nurses worked hard to prepare themselves and the profession for the changes they could see were likely to occur in the 1970s.

The 1970s

When the transfer of nursing education began, R.Ns needed to provide direct patient care in the hospital setting, instead of predominantly supervising nursing students. The perceived needs associated with the transfer included employing R.Ns willing and able to make clinical decisions associated with patient care, and to enhance the ability within the hospital schools of nursing to link theory and practice as was happening in the new polytechnic nursing courses.

The environment was still influenced by a hierarchical bureaucratic structure, but some responsibility organisationally was beginning to develop with team nursing and even primary nursing introduced in some parts of the country. R.Ns were returning to work part time in large numbers. More students began to live at home or flat with other students.

Decision-making needed to be linked to what really happened in the clinical area, meeting patients needs as individuals. Dissenting voices questioning current practice began to be heard. The pace of changing technology meant that clinical skills began to be acknowledged as important. Support for students was now beginning to be provided in the

clinical area by clinical teachers, the R.Ns in clinical practice, as well as by other students for those who still lived on the nurses home. Orientation and inservice programmes were provided for the R.N.

The schools of nursing began to broaden their curricula and introduced psychosocial concepts and the idea of theoretical principles. In writing the introduction to a selection of writings by Bea Salmon, over the period 1961 – 1981, the editors suggested that over the twenty-year period (1960s-1970s),

education for the health professionals including nurses has broadened to include the humanities and social and behavioural as well as the physical sciences. It has also focussed on developing the ability to think, to analyse, to reason to rely less on a circumscribed set of rules that are only useful in so far as the situation in which they pertain remains constant.

(Carroll, Fieldhouse, & Shaw, 1982, p.2)

In Miller's view (1976), the military tradition of strict discipline still dominated in the 1970s and this strict adherence to following rules and regulations did little to foster independent thought, indeed in most instances it led to group conformity.

Ford and Walsh (1994) suggest that one of the outcomes of the nurse being 'trained' rather than 'educated', is a nurse who is

an efficient performer of tasks, trained in the narrow confines of the procedure manual, trained only to see a standard solution to a problem and questions and alternative suggestions frowned on.

(Ford & Walsh, 1994, p.8)

All schools were not yet ready to broaden their approach or question the status quo. The continued focus on conforming to the rules was illustrated

well by Jocelyn Peach commenting on ‘training’ in New Zealand in the 1970s and the difficulty for some if you had an alternative view.

We were being taught and told to follow whatever these instructions were that had been set by Moses on the mountain, and if you did have an alternative view it was actually discouraged in one’s nursing programme. That was a challenge and a difficulty for some nurses in the group – if you were a conformist it was fine – you didn’t have to think about decision-making.

(Peach, 2.2)

Some of the nurse administrators of the day, however, began to realise that centralised decision-making and standardisation of decision-making were no longer appropriate. A more flexible approach was needed to meet individual patient requirements in a fast changing complex health service.

The complexity of transferring theoretical knowledge to practice in an increasingly diverse health care environment was also a real concern to nurse administrators of the day and meant that patient safety without close supervision could not be guaranteed. Orientation programmes and inservice education departments for nurses continued to be important as part of efforts to assist nurses develop competency in an increasing number of technical skills as well as maintaining awareness of professional developments (Department of Health, 1986; Moot, 1982; National Action Group, 1988; NERF, 1977).

Some hospital schools of nursing were also working hard to meet the changing needs of the workforce. Elizabeth Lee described her experience in Tauranga

We had a new tutor, AB. and she brought with her this new idea that you should correlate theory and practice, and that had never been done before in a hospital-based programme [in New Zealand]. We had modular training introduced and that had a huge impact on the way in which nurses had their experience and were supported...Your whole life was planned out for three years. You knew exactly where you were going and what you were doing and that seemed really good. That programme was looked at by a lot of people. I remember lots of people coming into the organisation, visiting and it felt good that that was happening.

(Lee, 1:4)

It was not until the late 1970s early 1980s, however, that most hospital schools in New Zealand began teaching broad principles or concepts that enabled students to more readily link theory and practice. This was an attempt to ensure that the hospital schools provided a quality of education that would enable students to respond to the increasingly diverse nature of health care, as well as to compete with the increasing numbers of polytechnic nursing schools. Evidence from both written and oral texts suggests that students were able to apply rules and follow regulations and policies to their delegated tasks, but when delegated tasks were no longer appropriate or when asked to apply the knowledge they were learning this became much more difficult. Drawing on Bloom's (1956) taxonomy of learning, some educators became concerned that while students could understand the concepts, applying broad principles was much more difficult. Many students found the ability to conceptualise and apply what they learned in their theoretical programme to their clinical practice a real problem. Even though they were not truly autonomous, they needed to problem solve, make decisions, and respond to clinical situations to keep people safe, especially on afternoon and night duty when the cover by registered staff was limited.

It was not only the students who had difficulty applying their knowledge. Lee Mathias in discussing the importance of decision making, commented that in her opinion, many of the senior nurses of the 1970s did not have the necessary knowledge or skill to assist the students learn, and the lack of application of theory and practice was often linked to the lack of knowledge of the ward staff. The senior nurses often felt threatened by questions they were unable to answer, so did not encourage application of theory and practice. It was also difficult to ensure that the staff in the wards knew what the students were studying at the time and how they could help them. Communication between the teaching staff, the students, and the ward staff was complex (Personal experience as a nurse teacher 1960s through to the 1980s).

The question of support for the students was another vexed question. As the hospital schools closed, students did not have the debriefing opportunities and support of peers living communally in the nurses' home. Other ways needed to be found for supporting and debriefing the students. The teaching staff working with the students in the clinical area generally did this at the end of a clinical practice session, but the significance of the need for this kind of support was not yet fully recognised (personal experience). The employment of staff and student counsellors also became more common in the 1970s.

This decade was less hierarchical than the 1960s with processes beginning to acknowledge needs of the individual patient, and the individual nurse as a skilled practitioner. Independent decision-making began to emerge in association with clinical practice and the primacy of the nurse was more widespread.

The 1980s and 1990s

When the qualified workforce was almost a reality, the perceived needs were for a competent R.N workforce that could meet the needs of

individual patients in a complex changing health sector. This continued into the 1990s when issues of the correct staffing skill mix became important.

The environment was more decentralised, clinical specialist R.Ns emerged, and the importance of the individuality of each patient was well and truly recognised. The changes in organisational structures in the 1980s, and the introduction of general management, saw a 'flattening' of the hierarchical nursing structure, the disappearance of many nursing positions and titles, and more localised decision-making became both possible and necessary. New Zealand nurses commented on the confining nature of the bureaucratic structures in which they worked. Hickson (1988), a New Zealand nurse academic suggested that we still had not got out of the hierarchical, bureaucratic model that became outdated years ago, resulting in some structures being historically frozen. The 1980s were however a decade where individual nurses were acknowledged for their clinical expertise and until the introduction of general management in the late 1980s, the role of the experienced nurses clinician and nurse consultant began to flourish.

Decision-making was now based on professional judgement, within an individuals the scope of practice and decisions were made as situations arose. Nurses had much greater individual responsibility, which was scary for some. R.N support was individually sought or offered through peer review, support and debriefing. The environment became increasingly deregulated and market driven, with funding requirements under pressure. Shortages of experienced nurses were a major concern and a variety of less qualified caregivers were employed in some health care settings.

When all nursing programmes were situated in the tertiary education sector the theory/practice gap narrowed from a theoretical point of view – for all students. What was being discussed and studied in the classroom

could also be studied and explored in clinical practice. It was, however, still important to assist develop that skill to move beyond comprehension and application, to analysis, synthesis and evaluation. All students now utilised problem solving and critical thinking and taking initiative in individual situations was expected.

The tutors went with the students to support and facilitate their clinical experience, assisting them to 'make the links'. A session was often set aside at the end of a shift to discuss the day and share learning with each other. Individual support 1:1 was also common. As financial constraints began to impact on staffing levels, the opportunities for 1:1 student support became less, as tutors needed to supervise larger and larger numbers of students over disparate clinical placements causing dissatisfaction regarding the standard of clinical supervision and support.

Mia Carroll talked about her experience as a nurse educator in the late 1980s early 1990s supporting the students from the polytechnic in clinical practice. They did not live together in nurses' homes and did not have the debriefing opportunities Mia herself had had with colleagues in the nurses' home.

I became the facilitator of their debriefing - I remember one [student] on her first clinical experience and her patient died. We debriefed, but she had to go home and sleep with mum and dad that night and I thought back to the levels of support and maturity that were in a nurses home – something later generations didn't have. We had a debriefing, reflection in and on practice, we talked to each other about our case loads, how we managed our days and we learned from each other an enormous amount ... and again when we were 'allowed' to leave, we flatted with each other and had the same support.

(Carroll, 1:3)

Support for the R.N was provided through orientation and inservice programmes and the idea of peer review peer supervision, and debriefing was introduced with varying degrees of success. Clinical supervisors or nurse educators were employed on each ward or unit in some settings especially when the R.N workforce was inexperienced.

The role of preceptors, mentors, and the concept of professional supervision became important in supporting both inexperienced and experienced practitioners. The importance of debriefing after critical/emotional events and the value of professional supervision was gradually being recognised and processes put in place to provide opportunity for those who found this helpful.

The introduction of the general manager and service management in the late 1980s, and a competitive environment within the health sector in the 1990s, resulted in some difficulties in sorting out who was responsible and accountable for decisions affecting patient care. The 'market model' applied to health and the idea of 'commercial sensitivity' also meant that decision-making was not perceived as being as collaborative as it was in the 1980s despite the increased patient focused approach to care.

Tensions still existed between the individual nurse and the demands of the organisation. Jocelyn Peach, shared her experience of working with people who can't work or think 'out of the box' in a number of organisations in the 1990s.

[These are] people who've ruled by 'rote' where you do things because you're told to do it and that's the way you do it round here. If you challenge at all, want to make alternative decisions, it's almost too hard. So that to me has been a case of how do you get past that...past the 'rote' for people if they're used to the concrete world and following rules.

(Peach, 2:8)

Nurses in Canada and the United Kingdom expressed similar concerns about the relationships between the nurse and the bureaucracy (Diaski, 1996; Jolley & Brykczynska, 1993). Jolley & Brykczynska discuss this impact on the patient suggesting that the interests of powerful groups within health industry can bind nurses to the behavioural expectation and systems of rules of the organisation rather than to the needs of the patients.

Decision-making, as a skill, requires professional judgement related to an individual assessment of a situation. Lack of experienced staff or inadequately prepared transient part-time staffs can be a significant barrier to progress for both an individual and the profession.

In times of nursing shortage a risk of reverting to task allocation and rules and regulations exists. This certainly impacts on the ability of the nurse to make effective independent decisions or to question processes that might appear to be unsuitable. The ability to 'step out of the box' and to do things in a different way is important when considering the needs of people as individuals.

The written and oral texts revealed that the preceptor/mentor/educator support provided in the 1990s to enhance independent practice was very different from the minimal support provided in the 1960s – 1980s, and that such support fostered and promoted nurses helping them to continue to make a difference effecting change in the future.

The evolving environment affecting decision-making has moved from hierarchical bureaucratic structures that inhibited individual growth and responsibility to deregulated decentralised structures where professional judgement by the nurse is both encouraged and expected. Understanding the environmental influences over time provided the base for exploring the second content area in this square of the quilt, changing patterns of decision-making.

Changing patterns of decision-making

The interpretive strategy of exploring the source material through a series of four contrasts enabled some clarity about changing patterns of decision-making over time. This brief section provides an overview of these changing patterns in nursing education, clinical practice, and nursing management as a precursor to exploring attitudes, beliefs and responses over time as revealed by the written and oral texts.

Many events impacted on the developments of nurses decision-making, and these influences were discussed and debated by nurse leaders, and grappled with by nurses internationally as well as by nurses in New Zealand.

Following a period of relative stability, and adaptations to changes brought about following the second world war, changes in practice and beliefs affecting the Registered Nurse developed significantly in the 1960s when the traditional patterns of nursing began to be questioned by an ever increasing number of nurses. Nurses in leadership positions in both education and clinical practice, as well as nursing students questioned the status quo. They questioned the education system, the appropriateness of students working in acute hospital settings, the pressures of work life, the apathy of nurses, the appropriateness of the nurse's role within the hierarchy and nurses resistance to change (Boyd, 1967; Burton, 1970; Cameron, 1963; Chambers, 1960; La Provocateuse, 1966; Orbell, 1960). The traditional hierarchical approach to clinical practice and the perceived unquestioning adherence to rules and rituals were now being critically examined and major change was in the wind.

In nursing education, decision-making moved through time from the 1960s where the 'nurse' (in reality, predominantly the student nurse) was taught knowledge and skills as outlined in texts and procedure manuals, with the idea that one size fits all. Many changes in medical technology,

increased patient acuity, and decreased length of stay in hospital saw recognition by the leaders of the day that attitudes and beliefs needed to alter to cope with these changes. This included consideration of 'principles' and 'key concepts' associated with knowledge and skills in the 1970s and the introduction of problem solving and the nursing process (Emerton, 1976; Marriner, 1975; Matherney, 1974; Yura & Walsh, 1973). In the 1980s the use of problem solving as a teaching and learning tool became popular as well as issues linked to the classification of nursing practice and work on nursing diagnoses (American Nurses Association, 1989; Reid, 1989). In the 1990s as writers focused more on the need for nurses to hold and act on expert knowledge, the importance of 'journalling', 'critical thinking' and 'reflective practice' was acknowledged (Barry, 1992; Bethune & Jackling, 1997; Boud, Keogh, & Walker, 1985; Daly, 1998; Facione & Facione, 1996; Heath, 1998; Holly, 1987; Palmer, Burns, & Bulman, 1994; Street, 1991). These concepts were taught in nursing programmes alongside the adoption of problem based learning which encouraged dialogue and recognised multiple realities. The sharing of exemplars and increased interest in storytelling was also a feature of the 1990s, used to enhance knowledge and support effective decision-making.

In clinical practice, decision-making over time mirrored nursing education, moving from task assignment and the unquestioning following of rules and regulations, of orders, lists or instruction by the student nurse in the 1960s, regardless of individual participants circumstances (Carpenter, 1971; NZNJ, 1960; Reid, 1965; Stevenson, 1997). A more flexible approach was needed to meet the individual patient requirements in a fast changing complex health service. The 1970s moved rapidly from task assignment and functional nursing through to team nursing and group discussion of nursing care, the introduction of primary nursing and the use of the nursing process and written care plans (Gordon, 1982; Henderson, 1986; Mace, 1984; Pitts, 1984; Roberts, 1980). Henderson (1984) a New

Zealand nurse presenting a paper to a nursing forum commented how as a charge nurse she had

evolved through the philosophies of task, cubicle, team, and patient assignment and now to primary nursing. All in only eight years! I suspect many of us could say the same.

(Henderson, 1984, p.144)

Some of the nurse administrators began to realise that centralised decision-making and standardisation of procedures were no longer appropriate. The 1980s saw an increasing focus on the decision-making requirements of the clinical nurse as nursing diagnoses became an integral part of primary nursing as the dominant mode of practice. The introduction of standards of practise and quality assurance programmes gave further direction and assistance to the practitioner (Carter, 1982; Foster, 1989; Henderson, 1982; Petersen, 1983). The 1990s have increasingly focused on the patient as the centre of care and decisions made through partnerships between the nurse and the patient, their families, and other health professionals. Decision-making now included critical reflective ability to assess a situation and accept responsibility for using professional judgement and legitimate authority for decisions relating to the practice of nursing.

Centralised decision-making with little delegation to individuals in the 1960s neither fostered initiative nor perceived individuals responsiveness was necessary. The primacy of the nurse while apparent among individuals was not widespread within the profession. We need to note the major shift over the decades to the 1990s where the importance of individual initiative and effective nursing decision-making was seen as crucial to meeting the individual needs of the patient. The process of decision-making for the individual nurse was now a key factor in ensuring the ongoing primacy of the nurse.

The first two content areas, the evolving environment influencing decision-making and changing patterns of decision-making emphasised the material gained from integrating the oral and written texts, and provided some sense of the environment and changing patterns over the four decades. The move from a hierarchical bureaucratic environment that required conformity to rules and regulations and supported centralised decision-making through the decades to a deregulated market driven environment that supported individual initiative with the patient at the centre of care, individual decisions based on professional judgement and legitimate authority in relation to the practice of nursing.

Having grasped the essence of the significance of decision-making doesn't necessarily answer the questions about how people go about it, and the attitudes and beliefs that underpin their decision-making responses.

The next two content areas provide some of the answers as revealed by the oral history participants' accounts in particular that are not easily found in the written texts.

Changes in attitudes and beliefs over time

The third content area in this square of the quilt is about the changing attitudes and beliefs associated with decision-making. Each of the participants in their accounts provided insights into when they first understood about making decisions - when they learned that decision-making was possible or really understood how to do it. I have selected several accounts to illustrate the changing attitudes and beliefs over the period. These accounts refer to the impact of change, resistance to change accepting the challenge to change, the 'handmaiden' attitude, the effect of education, and nurses' writings.

The impact of change on nurse's attitudes and beliefs associated with decision-making was a really important factor to explore. External changes in health and education policy have impacted on nursing and how nurses practice, as well as change within nursing itself. While post registration nursing education programmes in the 1970s and 1980s included the concept of change and how to manage change, the attitude of many R.Ns has predominantly been one of resistance to change throughout the period under study – an attitude that does not support the concept of primacy.

King (1977), a New Zealand nurse researcher, writing a report on a manpower planning workshop on behalf of NERF, described under the heading of impediments to planning for change, the attitudes and beliefs of nurses who cannot concede that nurses can be prepared outside a hospital setting. She suggests that "Beliefs can be held and attitudes maintained with some justification unless objective evidence can be provided to show otherwise" (King, 1977, p.8). To influence attitudes and beliefs, nurses as a group need to be exposed to issues and vigorous debate encouraged.

Nurses apathy and lack of involvement in the affairs that effect the nursing profession has been a barrier to such debate as well as a response of active resistance to change throughout our recent history. This can be said of the nurse leaders as well as the nurse at the bedside. Elsie Boyd (1967 p.13) a nurse adviser in the Department of Health, when reporting on her impressions of a study and observation tour in the USA, spoke of nurses' resistance to change "The nursing profession as a whole is resistant to change because it is itself a product of a narrow task oriented training". Margaret Bazley gave several examples of the magnitude of nurses' resistance to change over time, from her perspective, including resistance to the introduction of penal rates (additional payments for

afternoon or night shifts) in 1965, and to her career moves in the 1960s – 1980s.

I'd always been used to having penal rates in the hospital and I'll never forget the great debate and hostility expressed by the general nurses to penal rates. I just couldn't believe it – I'd gone from 'psych' to general, my pay had dropped to a mere pittance, and I had to suddenly start working short changes and split shifts and what have you without any compensation what so ever and there were these general nurses saying they wanted to continue that. It was amazing, the hostility that came towards that change and I guess that tells you...what nursing at that time was like. It didn't matter what it was – you actually resisted it –even if it was going to give you more money!

(Bazley, 1:4)

The personal examples for Margaret included the unbelievable disapproval of the Matrons of Psychiatric hospitals to her appointment in 1965 as Matron at Sunnyside, without going through the ranks. This was repeated in 1973 on her appointment as a senior public health nurse (PHN), with responsibility to get the PHN's organised to do 'psychiatric nursing' follow ups, and to teach 'psych' skills. This appointment was resisted by other PHN's as Margaret had not come up through the ranks, nor had she got her Plunket qualification. The value of her Comprehensive registration was discounted and twenty-eight nurses unsuccessfully appealed against her appointment. She was also the first public health nurse in Auckland not to wear a uniform or to have a car with 'Health Department' on the side because conditions had changed and that really upset the PHN's because they had all voted to keep their uniforms.

Her position as Deputy Chief nurse with the Auckland Hospital Board working alongside Margaret Millar whom she greatly admired was also difficult. On the one hand with the Board who were generally very conservative in their approach to nursing, and on the other the Matrons of the hospitals sabotaging nursing decisions at every turn. She experienced further examples of nurses undermining nurses – horizontal violence as it is referred to by some nurse writers (Moot, 1982; Farrell, 1997; Glass, 1997; Hutchins, 1992).

On her promotion in 1984 from the Director Division of Nursing to an appointment at the State Services Commission, there was a battle to retain the former position within the department structure. The Hospital Board Chief Nurses were unhappy with the direction of the Department, and did not see that their approach in failing to support the retention of the Director of Nursing position was destructive to nursing. Senior non-nurse members of the department then knew they could divide nursing and weaken the powerful Division of Nursing.

The profession's continued ability to resist change was expressed by Jocelyn Keith. Discussing a consensus conference in 1995 looking at 'The first year of nursing practice', she spoke of the real concerns expressed at that gathering including "*nurse's resistance to innovative ideas*" (Keith, 1:7).

Resistance to change was not confined to New Zealand nurses, Christman, an American academic, cited in Schorr and Zimmerman (1988), wrote of learning from an experience where he had not involved the staff and met serious resistance.

No matter where I worked after that...I always involved the whole staff in decision-making. I gained insight into how doggedly nurses resist change.

(Schorr & Zimmerman, 1988, p.47)

How to effectively manage change was a concern for individual nurses and the nursing profession during the turbulent decades of the 1970s and 1980s. In November 1981 a workshop attended by over 230 nurses was held at Waikato University in Hamilton. Part of its stated aim was “To increase nurse’s awareness and knowledge of predicted changes in the health services and to help them plan positively for their roles in the future” (NERF, 1981).

Papers presented included reference to innovations, standards, quality control, the challenge of change, and nursing on the move. Speakers presented a variety of views, cautionary tales and future challenges, with the after-dinner speaker who was not a nurse, reminding those present that “The closed mind sees no further than today, the open mind looks ahead, builds on the past, adapts the present, and plans for the future with hope and optimism”(Winstone, 1982.p.168).

Sally Shaw, when Director Division of Nursing, addressed a workshop in 1985 with her paper titled ‘Another time, Another challenge’. The time being where the majority of the New Zealand nursing services was provided by qualified nurses [R.Ns] and the challenge lying in the implications of this change. She discussed how our decisions and actions now would determine our future, and the challenges that needed to be addressed. She emphasised the importance of the high level of professional maturity we would need as a group to avoid attitudes and practices that would interfere with the resolution of many of these challenges including our ability to cope with change. Both examples mentioned above link the past, present and future and our ability to move forward, to create our own future.

The written and oral texts explored the rapidity of change that occurred in the mid eighties when nurse leaders of the day reminded their colleagues that while change provided both risk and opportunities (Pitts, 1983; Shaw,

1986; Shetland, 1976; Williams, 1987, 1989, 1991), nurses must seek out opportunities in the changing environment. Lack of confidence in their ability to act independently, meant that for many nurses risk taking was a limited possibility. Understandably this was especially so when the risk had financial implications. Some nurses however learned quickly, and they took risks, challenged the status quo, and made great progress with innovative ideas (Kinross, 1982; Petersen & Chandler, 1986; Spinetto, 1986; Ramsden, 1989).

What we believe about change is important. Our attitudes and beliefs influence our response to events and can be difficult to alter. Resistance to change can lead to ritualistic practice and the stifling of ideas, while embracing change can make a difference through positive creative and innovative responses. We have the choice to resist change and stay with our rules and rituals or to seek opportunities for growth of the profession and to be a driving force for change. As nurses' attitudes to change had a significant influence on our decision-making throughout the whole of this account, some comment about managing change and resistance to change needs to be included.

Sally Shaw in her role as Assistant secretary Workforce Development Department of Health, used the title 'Mind over mind set' for a paper she presented in 1985. She suggested that if nurses were going to practice in a truly professional sense

there is a pressing priority to address the matter of mind over mind set if we are to effect the kind of changes that I believe are going to be essential for Nursing's survival...I have taken this title from a 1985 editorial opinion in an American professional journal. It refers to attitudes, how they harden into mindsets, and how this

affects our ability to use our minds. Mind, over mind set, is essential if we want to effect change.

(Shaw, 1986, p.1)

There is some evidence that when attitudes and beliefs are stuck in a 'mind set' the nurse may tend to lack logic and to resist change. 'We've always done it this way'; 'We tried that and it didn't work'; 'just because you've finished that new course don't think you can come back and change everything'. Cleland (1987, p.1) suggests that between the period of 1911 – 1983, nursing literature internationally and nationally reveals that the nurse learned to act as expected and to "be obedient, respectful, conscientious, neat and clean, punctual, quiet and truthful". Cleland and others suggest that many nurses thought that these attributes were both desirable and 'professional' (Brown, 1991; Russell, 1990).

Internationally and nationally individual nurse leaders of the day since the beginning of recorded opinion, have talked and written about the need for nurses as a profession to accept the challenge, to embrace change and take the opportunities that arise – to be a driving force for nurses and nursing (Cameron, 1960; Lythgoe, 1976; Holdgate, 1969; Shadbolt, 1986; Shaw, 1989; Styles, 1993; Oulton, 1999).

Jocelyn Keith who supported the need for nurses to be entrepreneurial referred to the question of accepting the challenge, the opportunity. If we are to change and 'march', to lead the way forward, we need to develop the image of the entrepreneur.

An entrepreneurial able comprehensive...nurse making a real difference to health...We are not grabbing the opportunity. I was advising a group of district nurses recently (1995) – they had the perfect opportunity where they were building a brand new hospital - to get in on the ground floor. To think of episodes of care, to be there before [the episode], support during, then after hospital. They can't grab that nettle, it is too hard, too sharp, too dangerous, they are running away from it – they don't have the courage.

(Keith, 1:8)

Despite the fact that many nurses still actively resist change, we must not forget that throughout New Zealand every day there are R.Ns making positive changes that affect the health outcomes for New Zealanders, rising to the challenge and accepting the opportunities that reflect the primacy of the nurse.

It is not only the attitudes of nurses to change that we need to consider, but also the attitudes and beliefs of the community and other health professionals. The attitudes of both senior nursing staff and society in general in the 1960s and 1970s often gave students mixed messages about their personal responsibility. One day the student was senior enough to relieve the ward sister, the next she was back to cleaning the bowls. As the 'nurse' you were responsible for patients' survival – providing constant observations and monitoring the patients' progress, while off duty you were a little 'girl' needing to be told when to go to bed and woken up to ensure you were on duty on time.

The mixed messages about responsibility must have undermined students confidence in their ability to be responsible and to make adult decisions. This was reinforced by some writers of the day stating that women generally lacked initiative and ambition.

Ria McBride in an article about changes in women's work reported in the *NZMJ*, described her experience in the 1960s as follows.

Women have a short term view of any occupation, their dominant ambition is to get married and if possible go overseas before marriage, they are too subjective in their attitudes, lack initiative and ambition, are unwilling to accept too much responsibility in a job, and resent change.

(McBride, 1963, p.21)

There was no response to this article in the *NZMJ* over the next few months although letters to the Editor were not common at this time. Another writer during the 1970s suggested that women needed to gain more confidence in 'male activities' such as decision-making and thinking independently (Heide, 1973).

The sense of service linked to the influence of the church mentioned at the beginning of this section was associated with perceptions of the nurse by nurses themselves, as well as the public they 'served', and society in general (Ashley, 1974; Bickley, 1984; Jones, 1988; Shadbolt, 1986). Several international writers described the lay image of nursing as an extension of the female and mother roles, with many people thinking that nursing consists of simple tasks that anyone could perform (Glass & Brand, 1979; Muff, 1982; Salvage, 1987). The situation was similar in New Zealand – we are perceived as being

socialised to believe that our role as women and as nurses means putting the care of others before the care of ourselves...women's work holds a low status in this society and it is interesting that nursing work also holds a low status, even within the institution of nursing itself.

(Instone & Stevenson, 1987. p.2)

One of the common images in the 1960s associated with service was the image of the nurses as 'handmaiden'. Perhaps it is in the words of Jane Salvage, a United Kingdom nurse political commentator, that this handmaiden image of the nurse is best expressed.

The nurse is not seen as a skilled worker who tries to do a difficult and complex job, but as a selfless ministering angel whose devotion to the doctor and whose tireless efficiency as his handmaiden enable him, the true professional, to do his job while she soothes the patients fevered brow.

(Salvage, 1985, p.18)

Elisabeth Lee described the handmaiden routines of some of the R.Ns in the 1970s.

The routines of some of these people [nurses] in senior positions were around looking after the wants and needs of other people (namely doctors) and getting organised for things like the doctor's rounds. Making sure there was morning or afternoon tea, making sure that patients were in the right places for the doctor so the doctor wouldn't be disturbed or have to wait around unnecessarily, but not really actually focused on providing care or the patient's need.

(Lee, 1:6)

Perry (1993, p.43) in discussing the handmaiden theory from a sociologists view, suggests that "the handmaiden mentality and tasks of nurses are not natural female responses to human need or male technical superiority but the outcome of a system which openly supports separations between cure and care...it is a socially organised occupation". No matter what led to the concept of the handmaiden, the reference to the handmaiden image was a common one and hard to shake off (Jolley,

1993; Perry, 1993; Wootton, 1987). A Hospital Board Medical Superintendent addressing a Matrons' conference in 1964, stated that

Nursing of necessity is a handmaiden of medicine – the ultimate responsibility rests with a doctor with whom the nurse co-operates. But there is no reason why nursing should not share in the stimulating change which has occurred in the climate of medical thought.

(Henley, 1964, p.8)

In 1977 a Christchurch surgeon voicing his opposition to the transfer of nursing education from the hospital schools expressed in the local newspaper his need for a handmaiden thus: "As a medical officer, I want my patients nursed as I want them nursed" (Wootton, 1989, p.7).

Even in 1984, when the mainly qualified nursing workforce was making a real impact in the hospital setting, the Minister of Health sought to

remind you that in spite of this being your 78th Jubilee you are still seen by so many as the handmaidens of health care. Of course you are not the handmaidens. Your professional and caring skills lie at the heart of health care.

(Malcolm, 1984, p 14).

Ford and Walsh (1994), suggest that by virtue of being seen as handmaidens and the lack of in depth theoretical knowledge leaves nursing vulnerable to ritualistic practice. The danger then being that many new and potentially valuable innovations could go down the road to ritualisation if they are accepted without question.

Jocelyn Peach described how in the 1980s she felt that the medical staff did not like to be challenged by nurses questioning their instructions and that this persists in some areas today.

Really the medical staff like the handmaidens – they want them and that's why they put in place [overseas] physician extenders and everything else because they don't want a person who challenges them, who makes decisions without their input, who decides their decisions [the doctors' decisions] aren't good enough and will go over their head.

(Peach, 2:4-5)

This was not the experience of Nan Kinross who described her student days in the 1950s working with peers who also made decisions debunking the myth that all student nurses were handmaidens who just did as they were told.

The truth of the matter is quite the reverse – we were not poor downtrodden little things. If you were doing this [interview] with my mother for example who trained at Waimate in the early 1920s she will say that they did everything and as a sister in a private hospital she actually did all the stitching, she was the one that assisted the surgeons and so on. She remained a brilliant diagnostician into her 80's and I think it was because she had again lots of opportunities and quite a lot of support to make those decisions...When I went from Christchurch to Southland as Chief Nurse, I always remember the senior nurses and staff nurses coming to my office to talk about things and being very scornful about inputs about staff nurses from the big city hospitals.

[This was] for much the same reason – because they don't have the get up and go, they don't make decisions, and can't do anything unless they're told to do it.

(Kinross, 2:4)

The handmaiden image is in direct contrast to the primacy of the nurse. It is our attitudes and beliefs that will influence what our future response

will be - the choice we make – to be handmaidens, or nurses making a difference and effecting change.

An influencing factor that affected attitudes of several of the oral history participants was the availability of other nursing staff and the nursing environment of the time. Several participants spoke of the need to make those ‘crisp timely decisions’ when alone on night duty in their student days because there just wasn’t anyone else there and they needed to get on with it and accept the responsibility (Burgess, Keith, Kinross, & Shaw). Other participants talked of the increased ability to develop decision-making in settings where you nursed on a one to one ratio (Burgess, Carroll, Keith, & Mathias). You needed to develop confidence in yourself and your ability to manage.

In exploring with Nan Kinross the effect of changing numbers and availability of staff over the years she suggested that in her student days people learned to make decisions early, partly because there were practically no staff nurses, very few house surgeons or registrars so the students were the staff, there was no-one else. In later years when there were more senior nursing and medical staff, approaches to decision-making became more collaborative and a shared responsibility.

Lee (*Mathias, 2:15*) in describing her experience in the maternity area in the 1990s referred to the availability of overall staff support. She found that the expectations of the ‘lead maternity carer’ are 25-30% lower in Auckland than those in Huntly. In Huntly the staff was absolutely independent and isolated so they have to make decisions, there was no one else to call, but in Auckland they (including the obstetricians) hand over decision-making more easily, knowing that there was backup there all the time.

These examples raised questions about responsibility. When do we personally accept responsibility and make decisions? When do we pass an

issue to others for a decision? Do we work autonomously or collaboratively? These important questions are addressed in the next chapter.

To move forward in times of change we need to see change as a time of opportunity, a time to have courage and take risks rather than a time of crisis, or a time to resist change and conform to the status quo. If the profession as a whole had resisted change to nursing education in the 1970s we would have missed a significant opportunity to move the profession forward, to make a real difference. The effect of educational change on the attitudes and beliefs of both the profession and the individual nurse was revealed in the written and oral texts.

The effect of educational change and nurses' writings on attitudes and beliefs.

A challenge to attitudes and beliefs of the NZRN began gently in the 1960s and became a major force for change in the 1970s. Challenges were made to attitudes and beliefs regarding nursing knowledge, nurses as scholars and researchers, the content of our curricula, and how we cared for our patients.

Changes in attitudes regarding nursing knowledge were strengthened as nurses with advanced preparation in the discipline of nursing began to work in New Zealand nursing education programmes. This began in the late 1960s and has gathered momentum ever since. Bea Salmon became the Principal of the New Zealand School of Advanced Nursing Studies in 1967 after completing a MSc (applied) at McGill University. In the introduction to a selection of her writings, a student in her first class wrote:

Nursing education in New Zealand took a giant step forward when Bea Salmon re-entered our scene in 1967...Other influences were at work but nurses required direction and purpose, motivation and incentive, awareness of their potential and the climate to develop these creatively. Bea Salmon pointed the way and New Zealand nursing is forever in her debt.

(Cited in Carroll, Fieldhouse, & Shaw, 1982, p.3)

The editors of these writings suggested that “for most students it was first a shock and later a joy to be asked to think, to analyse evidence, to make decisions and to take responsibility for them” (Carroll, et al., 1982, p. 4).

Anne McDonald described noticing the change in the post graduate students over time as they came from backgrounds that increasingly encouraged the student to question and make decisions. She spoke of an instance in the early 1970s where this became a problem for the school as the Principal of the school was also one of the Assistant Directors in the Division of Nursing in the Department of Health, and thus had dual loyalties. The students asked for a particularly controversial person to speak to the class. The Deputy Director General of Health of the day refused permission as the person had “embarrassed three governments”—so the students were unable to invite the speaker. This must have been a shock to students in those days when they were being encouraged on the one hand to take responsibility and to seek to ‘know’, while on the other hand stopped from proceeding to know at first hand. The 1970s was also a time when the discipline of nursing began to be recognised in New Zealand as a field of study with knowledge content of its own. Nurse scholars joined the international debate around the question – ‘what is nursing?’

Jocelyn Keith in describing her growing awareness of this knowledge base of nursing and the knowledge base available in the university in the

1970s, realised the diversity of perspectives relating to nursing, and the significant potential contribution nurses with an academic preparation could make.

If we're going to make our real contribution to health we have to have a clear view of what nursing is...Despite everyone's reservations about nursing diagnoses, I do think that (especially when used with functional health patterns) that they can help the practitioner out in the field...in terms of getting a clearer view of what nursing is and what it is not. I think that it is quite interesting with the work I'm doing on [Florence] Nightingale, that that was the first question she asked [about nursing] 'what it is and what it is not...Once I got that one clear in my head I was able to help other people get it clear in their heads. That's been an important contribution I think, of nurses with a general university education, to nursing in this country.

(Keith, 2:2)

The debate about nursing and nursing knowledge was assisted greatly when we began to get easy access to textbooks and journals written by and for nurses. Our attitudes and beliefs were challenged as we read and explored the ideas of international scholars.

In the 1960s there was very little written by nurses about nursing that was readily accessible to nurses in New Zealand and certainly little about nursing scholarship written by New Zealand nurses. This limited the ability to debate issues and to foster new ways of thinking about nursing. Lack of research into clinical practice and lack of interest in research generally meant that there were few challenges to the old established ideas. Medical practitioners wrote most of the nursing textbooks and it was not until the latter part of that decade that the first nursing texts written by nurses, for nurses, became available in New Zealand. The

authors were predominantly from the USA where “nursing publications blossomed through the personal need for nurses to advance their own careers by ‘getting published’ (Heywood Jones, 1986, p.177). Nurses in New Zealand didn’t care what the reason was – we were so excited to receive books specialising in topics covering the wide spectrum of nursing care – by nurses and about nursing. Yvonne Shadbolt talks about the impact on her as a nurse teacher.

There was a huge market of publications from the USA – cheap, interesting, attractive nursing books and journals which were so much streaks ahead of anything coming out of the UK at the time. [Publications] that were nurse focused, patient focused, professionally oriented and we loved them. There is no doubt there was a great deal of enthusiasm for a great deal of the theoretical foundation coming out of the States.

(Shadbolt 1:2)

Marie Burgess, who began to write herself in the 1980s because of the lack of New Zealand publications, also spoke of the significance of these books.

Getting texts written by nurses whether they came from the USA or anywhere else was significant when you think about it at that time. Most of the texts we used in the 1960s were actually written by doctors.

(Burgess, 1:15)

The proliferation of ideas regarding nursing education and practice was also assisted markedly by the exciting new nursing journals that began to appear. Salmon (1984, p. 123) commented on the value of receiving professional journals from around the world “Such is the mighty power of the pen which draws together the most distant corners of the globe”. These journals were purchased by the nursing libraries of the day and

used extensively in nursing education programmes and courses. It is interesting to note that New Zealand nurse educators were predominantly influenced by ideas from the USA over this time, mainly because of the availability of texts and journals providing access to nursing research and the exploration of concepts important to the discipline of nursing. Those interested in nursing education travelled or studied in the USA, while New Zealand nurses interested in nursing administration initially went on study tours to the United Kingdom, which was the country upon which the New Zealand nursing system was based. The attitudes and beliefs that developed from these two different approaches to nursing may have influenced the widening gap that was perceived between what was taught in the educational settings and what existed in clinical practice.

Despite the availability of these written texts, many practising R.Ns had not been encouraged to read widely. Even in the mid 1980s when Registered Nurses commencing an Advanced Diploma in Nursing in a large metropolitan polytechnic were surveyed about their reading habits, less than ten percent stated that they read more than one nursing journal. Ninety percent had never been exposed to overseas journals and were certainly not literate in the language and discipline of nursing. Very few of these students had had any exposure to changing attitudes or beliefs about clinical practice as expressed in the nursing literature. Over the period of the course, a fulltime year of study, many of the participants gradually increased their awareness of the need for reading widely, sharing and debating ideas, and the significance of lifelong learning. This influenced their attitudes and beliefs and was clearly demonstrated in their responsiveness on return to the workforce on completion of the course (personal experience).

Opportunities for New Zealand nurses to write about their thoughts and experiences have always been there. The *NZNJ* began in 1908, but until we built up a critical mass of articulate confident writers we chose as a

group not to 'go into print'. National nursing forums that began in the mid 1970s provided the first real opportunity for the profession as a whole to hear from its members, and to record and publish collections of papers. The majority of the oral history participants in this study published papers presented at these national fora. These papers provided a really valuable resource for the individual nurse, and publication continued until the mid 1990s. New Zealand nurses now get published internationally, as well as in New Zealand in the *NZNJ* or the journal '*Nursing Praxis in New Zealand*'.

As a result of access to this wonderful source of others ideas, we began to broaden our nursing knowledge and (for the first time for many New Zealand nurses) to consider the psychosocial issues affecting our patients – to consider our patients as people rather than 'the stroke in Room A'. We began to acknowledge that patients had individual ways of doing things just like we did. We started to question some of the ritualistic practices such as – Why did we wake everyone up at 5.30 in the morning? Why did we need to wash, bath, shower, or sponge everyone by 10 in the morning? Why did everyone have to have their lights out and go to sleep by 9.30 in the evening?

The focus on the medical model relating to the cause and effect of illness was so strong that many nurses could not think in any other way (personal experience in many educational programmes). It was not until the writings of nurse theorists like Hildegard Peplau, and Dorothea Orem, became available alongside texts that covered the study of people as 'pathopsychosocial beings' that individual nurses began to think more broadly.

This was a major change in attitude, and took place first in the schools of nursing especially among the new graduates. Lee Mathias described how the first graduates for the polytechnics in the mid 1970s were different.

In 1976-77 we started to get the first grads from the comprehensive programmes who were [different] “horror of horrors” according to everybody else. I guess for about six months they were, because they weren’t very disciplined in the way they worked and of course up until then nurses had been very disciplined. Very process, very procedure [oriented], and so forth and to get these new comers who actually thought differently - they didn’t actually think about ‘doing a round of something’ or a collection of activities together for a whole group of patients. They thought about doing a collection of activities for one patient or at the very [most] for a small group of patients. So this was a major shift – to do everything for one person.

(Mathias, 1:2)

Care based around individual patient’s needs rather than the system needs was a major change, and the profession in New Zealand was generally slow to acknowledge this approach based on beliefs that each individual is different. These tensions were demonstrated when considering the curricula of some of the hospital schools of nursing where the ‘medical model’ of health care continued well into the 1980s. Medical staff still taught in the schools with a focus on ‘diagnosis, treatment and cure’, rather than individual care. As the polytechnic schools moved towards a more ‘holistic’ approach, the medical staff was no longer used so extensively. In fact some doctors complained that the curriculum changes eliminating their contribution meant the programme was ‘second rate’.

The dominance of the Western medical model of health care began to change within the profession as a whole, with the introduction of post registration degree programmes at Massey and Victoria Universities in 1973. Nurses became really excited about learning about nursing and the varying perspectives associated with health care. Once they started to explore the wealth of knowledge available many became quickly

convinced of the value of lifelong learning as expressed by many of the participants in this study. The content of the programmes gradually changed to reflect the knowledge attitudes and skills needed by the competent professional nurse. Early papers addressed such concepts as 'Human problems in nursing'; 'Social problems in Nursing'; 'Knowledge in nursing'; 'Studies in health care'; 'Nursing theory and research'; 'Nursing through the lifespan'.

In the 1980s nurse writers such as American academic Patricia Benner (1984) began to write about the importance of nurses systematically recording what they learnt from their own experience, collecting their own exemplars and pursuing lines of inquiry and research questions raised by their own clinical knowledge. A belief in ongoing personal development was fostered and nurses began to examine the attitudes and beliefs underpinning their practice, and to debate how to provide more effective health care.

In the 1990s when the polytechnics began to offer degree programmes, the ideas of critical reflective thinking, personal journalling, the importance of stories to enable sharing of experiences, and the significance of professional judgement were very common in the literature and were built into the curriculum. Post graduate nursing papers included 'Clinical inquiry – evidence for practice'; 'Advanced nursing assessment and practice skills'; 'Pharmacology for nursing practice'; designed to "facilitate nursing (and individual nurses) in leading and responding to a rapidly changing health care system" (Allen, 1996).

The long held belief that prior knowledge and understanding did not warrant being credited current qualifications was challenged in the 1990s and the principle of recognition of prior learning (RPL) led to many R.Ns upgrading their qualifications in a much shorter time than had been possible in the past. This also fostered the development of personal

portfolios by the individual nurse enhancing nurses critical thinking and reflective skills.

Nurses in New Zealand were becoming more aware of the globalisation of ideas. Many nurses travelled to attend conferences, to share their vision with colleagues from all over the world, and to explore new ideas. While eagerly seeking new knowledge, and knowing that we didn't have to reinvent the wheel, nurses in New Zealand were also aware of the need to develop ideas to suit the New Zealand way of doing things and not blindly following overseas trends. Victor Hugo (source unknown) is quoted as saying that while 'A stand can be made against an invasion by an army, no stand can be made against the invasion of an idea'. While email, the internet, and web sites specifically for nurses have increased our access to the experiences of others along with the ability to read documents and purchase books on-line, we do need to be vigilant in applying ideas to ensure they fit the New Zealand context.

Having explored changing attitudes and beliefs to decision-making over time, the next section outlines the responses influenced by these attitudes and beliefs. The primacy of the nurse is again revealed as we responded as individuals or as the profession to our changing attitudes and beliefs. It was primarily the written texts that revealed the response of the profession as a whole, while the oral history participants spoke more to the individual response. The responses of the individual nurse and the profession to changing attitudes and beliefs make up the **fourth** content area on this first square of the quilt.

Response: decision-making in nursing education and clinical practice

The response to changing attitudes and beliefs was not just one response – it was a complex response over time, with ups and downs, with apathy and resistance in conflict with positive response to change. Individuals at

times were way ahead of the profession as a whole (for example regarding perceived opportunity for nurse entrepreneurship); while at other times the leaders of the day needed to enrol the profession and lead them to a planned outcome (for example the transfer of nursing education). On rare occasions there was agreement among all parties of the need for change (for example the need to update the 1977 Nurses Act, although exactly how may be debatable).

The responses to decisions made over the four decades in relation to nursing education and clinical practice should be read with the background from the nursing context chapter in mind. Understanding has been built on sifting and exploring the oral and written texts through four sources of contrasts - national/international trends, big picture/little picture examples, time within and between decades, individual/professional perspectives.

One of the major responses to changing attitudes and beliefs was the decision-making related to the change in nursing education and the inevitable impact that had on practice. This response began tentatively and rather ineffectively in the 1960s with a growing awareness of the need for change to deal with the pressures on the system and continued with major change in the 1970s. The 1970s saw the beginning of the transfer of nursing education from the hospital schools of nursing to the tertiary education sector, and the commencement of post registration education at Massey and Victoria Universities. The 1980s saw consolidation of the direction taken in the 1970s, with increasing emphasis on education to enhance clinical practice. The 1990s saw the decision to take advantage of enabling legislation and develop undergraduate degree programmes in the polytechnics while as the decade draws to a close questions are again being raised about the direction for the future to ensure that the professional nurse is prepared for the advanced clinical practice demanded by the diversity of complex health needs. Each of these responses was

initiated and followed through by nurses, nurses who made decisions, who made change happen individually and within the profession as a whole. Examples of nurses illustrating their primacy in relation to changes in the 1960s-1990s are outlined on the following pages.

In the 1960s nurse leaders (in the Department of Health, the Nurses and Midwives Board and the NZNA) became increasingly aware that, similar to experience overseas, it was becoming more and more difficult to meet the demands for safe clinical practice in New Zealand hospitals especially when using student nurses (Carpenter 1971).

Everyone joined in the debate, the medical profession, the hospital administrators, the public, and even the politicians. Nurse leaders wanted change and could see that the continuation of hospital based nursing education with the consequential primacy of service needs could not safely meet the demands of the rapidly changing health service. The Department of Health 1969 report *A review of Hospital and related services in New Zealand* clearly stated the position of the nurse leaders in the Department.

[Schools of nursing have] largely sprung up in terms of expediency...based on nursing service needs rather than on educational opportunities...today can only be regarded as wasteful of resources particularly in relation to qualified staff...In the existing three year programmes it is not possible adequately to prepare nurse for first level positions in a comprehensive nursing

service in which they are required to assist in a responsible way to promote health, prevent illness, and care for the sick.

(Department of Health, 1969, p.41-2)

In 1960 following a period of study overseas, Elizabeth Orbell, then Principal of the Post Graduate School wrote an address titled 'What is

nursing and who should do it?' She wrote of her concern at the 'flight from the bedside' in New Zealand.

Much has been said and written about 'flight from the bedside'. Unfortunately in order to advance in the profession, the nurse has to leave the bedside for seemingly higher positions in administration or education, and we may be in danger of growing too far away from the central core of nursing – the patient.

(Orbell, 1960, p.7).

World-wide debate during this decade resulted in leaders in the profession asking the questions – 'who should nurse?' and whether the R.N should be the 'provider' of nursing care rather than the 'supervisor' of care personnel. Dulcie Newman, Deputy Matron in Chief, Christchurch hospital asked these questions in 1963 – "Who is doing the nursing?" and "Where are we going?" She wrote of the fragmentation of clinical experience, the loss of close patient contact, and asked several questions

Is she [the nurse] too busy to remain at the bedside?...Is the New Zealand R.N of the future going to be so status conscious that basic nursing care is no longer her concern?...Has her professional status grown and is the patient as a person, still her whole concern, or is her skill in interpersonal relationships giving way to technical ability...What is real nursing?

(Newman, 1963, p.7)

A hospital board administrator in an address titled 'Decision-making: near the bed' expressed his belief that as a practising hospital administrator and an ex-patient, competent nurses should make decisions at the bedside.

The further away from the patient's bedside the decision making of hospital administration moves, the poorer it is likely to become...in the preliminary remarks [of a report] we made the self evident point that decision-making should be delegated to the lowest level at which competence could be demonstrated.

(Horne, 1975, p.25)

Despite the wide ranging debates and comments, the 1960s did not see much change in clinical practice other than a series of reports and little action as described earlier and increasing pressure on the student workforce. Reid (1965) described the profession as “weary from the burden of traditionalism” but still needing to continue to keep up to date.

[Nursing still] carries on in a fast moving, changing society, and gives its nursing services in a field where scientific and social discoveries and changes happen almost overnight. In the past and even today, expedients, patches and palliatives, rather than fundamental change have too often been applied to nursing in an effort to ‘keep it in the picture’. This process cannot continue indefinitely without profoundly negative effects upon the service, which the profession renders to society.

(Reid 1965, p.10)

The 1970s response to changing attitudes and beliefs in nursing education was the trigger for the consequential changes needed in clinical practice.

After the transfer of nursing education from the hospital schools had begun, the question then arose of the need to change the provision of nursing service. Debate among the profession led to the decision that the N.Z.R.N should be the provider of nursing care, and that we should work towards a qualified nursing workforce in New Zealand. This was made explicit in two key documents in the 1970s.

In the 1974 Board of Health Report, *An improved system of nursing services for New Zealand*, recommendation 2.3 read as follows: “that Health agencies be asked to plan to ensure that gradually over a period of 10 – 12 years, all professional nursing services be provided by nurses registered under the Nurses Act 1971” (Board of Health, 1974, p. 7).

The 1977 *New Zealand Nursing Manpower Planning Report* included in the introduction the clear intention that “ Nursing services [in hospitals and the community] will be provided by registered nurses who have been prepared in a comprehensive programme in the general system of education” (NERF, 1977, p.6).

The assumption of responsibility for decisions and their implementation affecting the education of nurses and the practice of nursing did not come easily for some individual nurses or for the profession as a whole. This is clearly illustrated in considering the attitudes held by nurses in relation to the transfer of nursing education to the general system of education. Yvonne Shadbolt describes the variety of views of those involved in the nursing education as follows

They swung like a pendulum between huge evangelical desire to bring about what they considered to be the ‘reforms’ of the future and a great deal of hope and optimism about what those changes would mean, to total despair and pessimism as report after report came out that pointed to the deficiencies of both the [current nursing] education system and the people in it (people like me) and the services that were being offered by that workforce.

(Shadbolt, 1:4)

Those involved in nursing service (administration) had widely different points of view too, with a few highly influential nurses clearly seeing that it was not really a hospitals job to educate nursing students – they would be better off being prepared in the general system of education. The

majority, however, were primarily concerned with service provision. Carpenter (1971) reported that

The Matrons expressed concern with regard to the quality of care and their dependence on students to meet the service needs of the hospitals. They fear a change in the system may further influence the quality of care as it might be difficult to secure registered nurse who would be willing to staff three shifts.

(Carpenter, 1971, p.20)

At this time the Matron of a hospital was also the Head of the School of Nursing. To lose the school meant losing power and status.

Most were really only concerned about how to staff their own hospitals and responded in the only way they knew by seeking to increase the numbers of students at the bedside however and whenever they could. They also had enormous status and power in the system as the head of the nursing service and the school of nursing. The proposal to transfer nursing education out of the hospital schools was asking those Matrons to give away half their power.

(Shadbolt, 1:5)

Another reason that led to the resistance to change response was that as a profession we were also influenced by an entrenched belief about the international standing of the 1960s New Zealand nurse without a great deal of evidence. We believed we were the best so why should we change.

*We believed that we really had one of the best if not the best systems of preparing nurses – Our nurses were **the best in the world** and if you have produced the best, you do not throw away the means of so doing lightly*

(Shadbolt 1:5)

During the 1970s, however, there gradually developed an understanding within the profession as well as by individual nurses that clinical practice in New Zealand really did need to change, not only to ensure the provision of a safe professional nursing service, but also to accommodate the expectations and competencies of the new Comprehensive graduate (Burrell, 1974; Christman, 1978; NZNA, 1984).

The increasing number of Registered Nurses replacing nursing students as the providers of care at the bedside was another response to the need to change to meet the changing education developments. To encourage R.Ns to return to the workforce, and to assist them adapt to the changing nursing service demands, orientation programmes burgeoned, 'back to nursing' courses developed and nurses with young families were employed part-time and on a casual basis.

To assist the profession to come to terms with the rapid changes needed in the nursing service area to prepare for an R.N workforce, NZNA took a leading role. In 1972 the NZNA Professional Services Committee Nursing Service Section presented guidelines for use while the recommendations of the Carpenter report were being implemented as a matter of "great urgency." Recommendations in the guidelines suggested that: the roles of qualified nurses be redefined; the senior nursing structure reorganised, job descriptions reviewed to increase the clinical component of the work of the R.N. In addition, nursing staff development programmes should be introduced with particular attention to: return to nursing programmes; orientation programmes; skill training programmes for nursing practice for all categories of staff; and retraining programmes for staff whose job content is altering (Professional Services Committee, 1972, p.14 – 15).

In 1976 the NZNA committee prepared two position papers. 'Nursing service expectations of the beginning practitioner' and 'Guidelines for orientation of beginning practitioner'. The papers were prepared to assist nursing leaders of the day respond effectively to both the increase in part-time R.Ns returning to work, and the graduates from the new polytechnic courses. Interest in new modes of practice suited to an R.N workforce developed, and over the next few years the *NZNJ* published many articles outlining ways to individualise patient care adapted to fit the New Zealand context (Christensen, 1976; Corry, 1976; Hutchinson, 1975; McCallum, 1974).

Throughout this period of change many different ways of assisting nurses to assess and analyse their work were developed. In the 1970s the development of polytechnic nursing programmes and the University programmes at Massey and Victoria encouraged developing nursing knowledge, and understanding 'ways of knowing'. Patient history sheets were developed to assist the nurse to obtain key information about a patient on admission and enable her to diagnose the patient's need for nursing. Care plans and problem-oriented records were among the diverse group of tools developed during this time. Problem based learning was fostered in several schools of nursing.

Jocelyn Keith described work she did with district nurses using nursing diagnoses associated with functional health patterns.

Problem oriented records that we were required to use were getting filled up with all sorts of rubbish like 'slept well' or its equivalence, and P.M. who was in charge of district nursing service said to me I was to do something about it. I read Marjory Gordon's book, 'Functional health patterns' and I thought this just

might work for our district nurses so they had to come every Wednesday afternoon from 2–4 p.m. and the end goal was a case study that they presented to the class. They presented with three overhead transparency machines...they identified the problems in the setting they were in...what they and the patient wanted to achieve in relation to that problem...all the interventions... and suddenly they had a disciplined way of thinking about their practice. They knew the set up, their patient, better than anyone else in the audience and they presented wonderful, wonderful work.

(Keith, 2:3)

As Registered Nurses increasingly provided direct patient care throughout the hospital, it was realised by many nurse administrators that different modes of clinical practice needed to be introduced. This response was linked to the recognition that it was entirely inappropriate to have experienced Registered Nurses using the inflexible lists of tasks, or working in a hierarchical structure if the profession was promoting Registered Nurses as independent practitioners, accountable for their actions, and with increasing credibility and self-confidence. The need for independent decision-making related to clinical practice was becoming more apparent. A new comprehensive graduate speaking at a nursing forum put it like this

If we fail to give nurses the opportunity to contribute and put into practice what they have discovered in the course of further study and inquiry, they will have been doubly cheated...Tensions and discrepancies become apparent when nurses are expected to be autonomous and accountable in giving patient care, but find that the organisation of nursing services is highly centralised.

(Moot, 1982, p. 206)

Nursing education programmes all introduced teaching related to modes of practice that were more appropriate for a Registered Nurse who could think critically, problem solve, and make appropriate professional judgements. These concepts were included in Post-registration courses at Massey and Victoria universities; the School of Advanced Nursing Studies; and when that closed in 1978, in the Advanced Diplomas in Clinical Practice, offered by several of the polytechnic schools of nursing.

As a critical mass of nurses with an educational background in different modes of practice returned to work at the bedside, efforts were made to introduce these new ways of work for the Registered Nurse with varying degrees of success. Some nurses seized the opportunity to make change while others found the challenges too difficult and sought to maintain the status quo by resisting change. The move away from the 'protection' of task orientation meant that nurses were more intimately involved with the same patient for a longer period of time and it was more difficult to avoid talking with patients and their families about their concerns. The need for orientation programmes and inservice education about modes of practice became acute as team nursing, patient allocation and primary nursing became the dominant modes of clinical practice. A nurse unable to make those 'crisp timely decisions', or to communicate effectively and create a relationship with their patients, was increasingly out of place. Positions for clinical nurse specialists were recognised and valued as a resource for less experienced nursing personnel.

The decision to introduce these different modes of practice, team nursing, patient assignment, and primary nursing, was a response seen as appropriate in the new environment of a qualified workforce. Some nurses found this individualised approach to care a wonderfully liberating experience after all those standardised lists and procedure books, while others did not have the skills to move so comfortably from a standardised

regime. Lee Mathias illustrates this very well in describing her project of introducing primary nursing into a large metropolitan hospital in 1977/78.

*The mindset change was just phenomenal, just phenomenal. The [project] would have been the biggest thing I've ever done because it was such a huge change to the way people thought about nursing...There were some R.Ns who had a lot of difficulty doing quite simple nursing tasks – not usually because they couldn't do it because they – really they were a Registered Nurse! For some of them – they didn't **do** nursing, so we had to find a special staff nurse to do that.*

(Mathias, 1:2)

The transition period moving to a qualified workforce and introducing different modes of practice not only affected the role of the individual nurse, it also impacted on the responses of medical consultants and the ward charge nurses.

Mia Carroll described the initial effect on the medical consultants, of the introduction of primary nursing in a newly opened hospital in the 1980s.

We were very client centred. I happened to have two consultants who were willing to run the gauntlet...clinical credibility was established and those guys were willing to take a risk. I remember A.C. (Senior Consultant) coming into the office after he had done his first ward round with the primary nurses case load which meant he'd gone from room 'A' to room 'F' to room 'G' to 'A' to 'M' to 'A'. He walked into the office, threw himself into a chair, wiped his brow and said 'Oh Mia - where is the exit?' He was so bemused but he said it was worth it. The nurses were stunning.

(Carroll, 1: 11)

A great deal of time was spent in inservice education programmes to assist nurses to begin to function at a more developed level. This was especially important for those nurses who had not developed a critical thinking approach, or who did not feel comfortable about making professional judgements.

As nurse educators began to include problem solving, professional judgement, reflective practice and critical thinking in their teaching, nurse clinicians were writing about decision making in their area of practice alongside the impact of clinical judgement, clinical inferences, diagnostic reasoning, intuition, pattern recognition, professional judgement and problem solving on their practice (Benner & Tanner 1987; Grier 1976; Jones 1988; Offredy 1998; Tanner, Padrick, Westfall, & Putzier 1987). A critical mass of capable independent decision-makers began to emerge to enhance the experienced staff already in practice.

In the 1980s alongside the move to a qualified workforce, the profession used the context of national fora to debate how to move forward. Sifting through the national written sources in the 1980s the concerns of the NZRN emerged and were reflected in the titles or aims of these NERF-initiated National Nursing Forums. The forums reflected the perceived challenges of the day. In 1981 (p.1) the aim was “to increase nurses’ awareness and knowledge of predicted changes in the health services and to help them plan positively for their roles in the future.” In 1983 (p.1) the aim of the forum was “to provide a setting to explore: present realities and future possibilities on nursing, factors influencing nursing practice, alternative approaches to health care, and new dimensions for nursing”. In 1985 the forum was titled ‘Horizons of Care’. In 1988 (p.1) the forum was exploring “priorities for practice, and the challenges confronting nursing in a changing world.”

In 1987 NZNA hosted an International nursing conference prior to the ICN Council of Nurses (CNR) meeting in Auckland, New Zealand, with the theme 'Challenges options and choices'. The keynote speaker was Dr. Margretta Styles, then President of the American Nurses Association, addressing the topic of "Empowering nursing in a changing society", and many of the speakers including used 'challenge', 'conflict', and 'choice' in the titles of their papers.

In the 1990s the nature of the forums changed, reflecting changing opportunities available internationally as well as locally and regionally. Individual nurses now travelled to conferences tailored to their particular interests or specialties. While international nurse scholars continued to be invited to visit by NERF, they were also invited by other groups especially the educational institutions, to meet specific needs of the students or faculty. Nursing groups also planned national conferences to address one particular topic, for example, in 1991 a committee representing several nursing organisations planned a forum on nursing and midwifery education 'Vision 2000'. In 1992, NZNA planned a clinical career path forum 'A clinical career path for nurses'. In 1995 a group planned a 'consensus conference' seeking agreement on the topic 'The first year of nursing practice'.

The 1990s saw rapid major structural change in the Health service and Registered Nurses struggled to adapt (Baumann, 1998; Duff (1995/96); Kee, 1996/7; Lawther, 1999; NZNA, 1991). Those who grasped the opportunities brought about by the changing times increasingly needed to develop and utilise professional judgement and legitimate authority for decisions relating to the practice of nursing. This was reflected in the educational programmes preparing students for registration as a nurse and in the increasing number of postgraduate programmes offered by a wide range of educational providers. It also led to a response by the profession seeking change to the Nurses Act (1977) including the introduction of

competency based practising certificates. Ethical guidelines were updated by NZNO, and the Nursing Council introduced a 'Code of conduct' as a guide to professional practice. In the latter part of the decade, in recognition of the changing patient profile in our acute hospitals, the place of specialist practice and advanced practice are 'hot topics'. This is so internationally as well as in New Zealand (Christensen, 1999; ICN, 1992).

As outlined in the context chapter many experienced nurses left clinical practice in the 1990s for a variety of reasons. This led to increased workloads for those still employed especially new graduates. The nurse workforce became increasingly a part-time casual workforce (Dickson, 1992). With a decreased emphasis on orientation for new staff, lack of skilled preceptors for the new graduate, and ongoing economic constraints on health service providers, pressures on individual nurses continued throughout the decade (Dickson, 1992; NZNO, 1995a). New graduates found working effectively in acute hospital settings difficult as many were expected to function immediately as a competent Registered Nurse. It was difficult to persuade non-nurse managers of the need for orientation, preceptorship, and mentoring for the beginning practitioner, and this meant that the critical mass of confident and competent nurses was reduced in some areas. Lack of support for and lack of confidence felt by the newer graduates meant that competent decision-making in some areas was lacking.

Mia Carroll describes her feelings about new graduates' ability as effective decision-makers in the 1990s.

The beginning practitioner is limited in their decision-making processes their assessments are limited and their cues are limited depending on their anxiety and their knowledge level. It's as we progress that more and more filters come in to expand our vision and our decision-making so I describe the growth of nursing

practitioners as an hourglass. That we come out with a broad superficial knowledge of comprehensive nursing which is not to be sneezed at or scoffed at but then as we focus on an area of practice our decision-making grows in strength because of confidence and affirmation that it's the right decision-making. As we mistress or get hold of that area of speciality, our vision branches out again to be able to encompass more influences...We need to acknowledge what alters is the quality of the decision – making and I guess that means quality to whom and on what basis. For the manager the quality of decision-making may be governed by dollars, for the practitioner it may be governed by something else, for the profession something else – it's a very complex process really.

(Carroll, 2:1)

There is evidence that the struggle with the R.N accepting responsibility for decision-making still existed in the 1990s. In 1993 a General Manager of a Crown Health Enterprise reported his astonishment at the number of times nurses asked him for permission to carry out what he perceived to be obviously a nursing responsibility. He could not believe the lack of acceptance of a decision-making role by those he regarded as senior experienced nurses (Williams, personal communication).

This question of individuals 'seeking permission' or waiting to be given approval to proceed was a matter of real concern for the profession as a whole. If such an attitude was widely prevalent, how could we ensure we would participate fully in the provision of nursing care, let alone participate fully in issues of health policy and planning. This contrasts clearly with Jocelyn Peach describing her own attitude to decision-making.

I guess it's something to do with my upbringing...I have a philosophy that can be quite risky at times – if you don't have a

clear understanding of accountability. [The philosophy] is 'It is easier to beg forgiveness than to ask permission'. You know occasionally I have to eat humble pie, but generally I've had to work clearly in my mind why I'm doing something and then in the absence of anyone else being clear about what they wanted, I don't wait around for permission. If I think a decision needs to be made, I think it through very carefully. I consult with people who I trust to give me clear feedback that I'm not completely way off – so I seek coaching where it's appropriate, but I am also prepared to make a decision.

(Peach, 2:7)

The response of the profession to decision-making in nursing education and clinical practice over the four decades, has been a journey that began with tentative rather ineffectual efforts in the 1960s. Spurred on by individual and professional attitudes and beliefs about the need for change in the education of the nurse, major change occurred on the 1970s and 1980s with the education of the nurse firmly situated in the Tertiary education sector, in polytechnics and universities. Simultaneously nurse leaders recognised that the context of clinical practice was not congruent with the needs of the graduates from the polytechnics and modes of clinical practice changed acknowledging the role of the R.N as the key provider of patient care. The challenge for the NZRN of the 1990s was to build on the foundation of the previous decades and grasp opportunities to learn from the past experiences to inform their present and create their possible futures.

This learning can be explored by revealing how the oral history participants responded and lessons we can learn from their experiences.

The oral history participant accounts reveal how they personally learned about making decisions or when they first understood that decision-

making was important or that they were free to make a decision. Again the written texts do not reveal much of this personal material so I have paid particular attention to the oral texts.

Each of the participants shared insights into their individual understandings over time and their particular ways and learning are explored illustrating the diversity of understandings. Some participants had made decisions all their lives, others had learned at a particular time or in a particular context that such a thing as nursing decision-making existed.

Another aspect not revealed in the literature was how nurses could help others learn about decision-making – how to support decision-making in practice. This next section provides a synopsis of some of the key processes the participants used to help others learn.

Participants responding to making decisions, and supporting others

Having explored attitudes, beliefs and responses from a broad perspective, utilising the contrasts of big picture/little picture examples, national/international trends, time within and between decades, and individual/professional perspectives, I decided to examine the oral history participants' perspectives, in more detail - the insider story, more of the little picture. I have begun to establish the importance of effective decision-making in surfacing the primacy of the nurse, and the participants' responses support that perspective. Their experiences enabled me to identify the attitudes, beliefs and responses regarding decision-making that are key factors influencing our future.

The participants' decision-making responses were influenced by many attitudes and beliefs, learned as they grew up or linked to personal

learning, teaching, confidence and self belief, flexibility, courage to change, empowering others, and a clear vision to guide decisions.

Discussion with the oral history participants ranged over many issues including defining a 'nursing decision' and how their own decision-making practices changed over time. The significance of what comprised a 'nursing decision' was raised by a number of participants. Lee Mathias learned very early in her career what defined for her a 'nursing decision' as described in 'vignette one' at the end of this chapter. This was, however, not the case for many nurses in her experience.

We had a lot of nurses who had never made a decision, a nursing decision, and not necessarily new grads. In the mid 1970s to mid 1980s I spent a lot of energy teaching nurses, R.Ns who had been practising for some time, how to make nursing decisions. Many of these nurses had never recognised that there was such a thing as a 'nursing diagnosis' or a problem or patient state, that was going to be fixed by a nursing activity and not by an activity by anybody else in the health team.

(Mathias, 1:2)

Without the benefit of post registration educational opportunities for the NZRN until the 1970s, the importance of decision-making was not explicit for many nurses. Yvonne Shadbolt thought that the fact that there was an area of nursing that she was responsible for and could make decisions about as part of her practice, was not a perspective that came early in her career.

I think the awareness for me that there was a body of nursing knowledge and an area of nursing practice that I was 'in command' of, if I can put it that way, came late for me - I made

*contributions as part of 'the team' but not really from the point of view of 'this is a **nursing** contribution'...and I don't believe thinking back on it that any other health professional did that either that I can remember.*

(Shadbolt, 2:2)

Even when you are aware that effective decision-making is an important skill, it can take time to learn the 'how', and often a framework was needed to make understanding explicit. Mia Carroll described how for her decision-making was a process that went through a series of filters that have developed over time.

I'm very clear that my decision-making goes through a series of filters. They've come somewhat with maturity, and education has helped uncover those filters...Study with David Seedhouse around ethics has helped me uncover/unpack some of the values that drive my own decision-making processes...I think we are teaching much more about the process of reflection so that people can understand what influences their own decision-making. I spend time naming concepts for people that are inherent within their decision-making like a positive or negative concept, an ethical concept, or a wellness philosophy. I want people to see that they are using a particular perspective.

(Carroll, 2:2-3)

The question of whether the actual process of decision-making changed over time received a variety of responses. Three of the participants were quite clear that they had learned to make decisions as children, it was expected of them, and they had continued to make decisions throughout their lives whatever the context.

Sally Shaw was very conscious of having made decisions from a relatively early age, and learning to live with the associated discomfort.

I remember that I often got into trouble for making decisions...whether it was in the family, or what your parents wanted, or whether in school ones [decisions] that sometimes went against what was accepted as the status quo. So it wasn't comfortable, and I guess that you have to learn to live with that discomfort, and learn from that discomfort.

(Shaw, 2:2)

Nan Kinross was also expected to make decisions early on. She recalled one particular instance in her childhood where the expectation was that she would have responsibility for a decision regarding a family journey, and the 'sheer terror' of her reaction.

Well I would be about 8-9 [years old] and every August my sister and I went to my aunt who was Principal of a Maori girl's college. My father usually used to get the bus tickets for us, but on this occasion I had been ordered to get the tickets. I was told I could go and get the bus tickets and my reaction to this was sheer terror. It is often quoted in my family that I said 'for years and years I'm not allowed to do anything and now I'm being plunged into life'. But I can remember that feeling of terror about being responsible for going and getting – making decisions about the journey – so I have to say that in our family quite early on we were expected to make decisions, to decide on what we were going to do. We'd have support – we might have criticism about those decisions but we were expected to make decisions.

(Kinross, 2:2)

Jocelyn Peach tells a lovely story as she recalls a precise moment in her childhood when at the age of 7 she was faced with dealing with a motor accident while her parents were away. Her father was a doctor and she had often assisted him in his surgery.

My father's rooms were attached to the house and they didn't have an ambulance in the place we were in. They brought two people in [to Dad's rooms]...My parents were away at a wedding and I was with the young woman who was looking after us...and the people were bleeding all over the place - so I said you'll have to take them to the hospital but let me bandage them first...so I had these big bandages on - all the right bandages, and sent them off to the nearest hospital which was about 2 hours away. The sister in charge of the emergency department called up a few hours later and said - "who was that little person?" and my dad said "oh that's my daughter" and mum said - "she'll be a Matron"...I think I've always been a sort of pushy character...I've always had the belief about - if it's the right thing to do, you do it.

(Peach, 2:18)

It would appear that for some nurses the need to make decisions had been so much part of their lives that it carried over into everything they did. Even as student nurses in what some find confining and inhibiting environments, they went ahead and made decisions when the need arose. As well as influences from their childhood, participants identified particular influences or instances that were significant for them in recognising the importance of decision-making. Some of these influences included strategizing, developing frameworks, academic learning, recognising a sense of responsibility, observing others making or justifying their decisions.

Margaret Bazley was conscious of the importance of having a vision and of strategizing in order to make decisions and to get things done.

I spent hours working out my strategies you know and that's the problem solving - working out how you actually can do it...I never give up...often you hit the wall and I always think well you live to

come another day and I back off and work out another strategy.

(Bazley, 2:6)

Lee Mathias recalls being influenced over time by many different people and events including role models and expectations of enlightened medical staff. She felt that academic learning was the main influence in developing her own decision-making ability. Being able to clearly define for her what nursing was and therefore what was a nursing decision and what was not.

Marie Burgess doesn't remember being specifically taught - 'now we are going to cover decision-making', but thought that for her, decision-making was linked to a growing sense of responsibility for her actions, and the recognition of the weight of some of those responsibilities.

You became – even if you didn't give it that title, conscious of the weight of that decision-making and the responsibility you carried...in a busy surgical ward where you went on [at night] and it was dark, and people had had operations that day, and you had to know what was wrong with everybody and who were the people that you needed to watch, and what records to keep and so forth. You were always frightened that somebody was going to die in the night and you hadn't got around and done everything.

(Burgess, 2:2)

Marie did, however, specifically remember a consciousness about learning about decision-making in the 1970s when the 'problem solving approach' became fashionable and when the 'nursing process' was introduced.

... in terms of a recollection, actually saying – Oh! this is about decision-making, this is actually theorising what we've been doing.

(Burgess, 2:2)

Jocelyn Keith recalled the influence on her thinking of a small book called 'Getting to Yes'.

[The authors] identify different ways in which people structure their argument and suddenly I started looking at all these models and I thought 'of course' there are a whole lot of different approaches to this. They advocate a principled approach – one on which you focus on the issue not on the person – and so on. They also give you 'handy hints' on what to do if – 'what if they start playing dirty tricks' 'what if they are bigger than you' and so on - it's a very useful little book. It suddenly made me realise there is a theory to this decision making stuff and it was quite simple to learn. Once I got that one straight it was an enormous help and I realised that having been married to a lawyer and [he] had trained me for that kind of thinking, because of course he focuses on the issues not the person, and I hadn't been aware of it.

(Keith, 2:2)

These accounts reinforced the importance of learning how to make decisions – as a process it can be learned aided by academic learning, personal reflection, role models, and strategizing. Having learned the 'how' we needed to be aware that we could do it – that it was allowed – we had permission to make nursing decisions. Jocelyn Peach became particularly aware of the important influence of nurses and decision-making in the 1980s when as an R.N she attended a conference where she observed nurse leaders of the day debating and defending decisions. It was for her a sudden awareness that nurses could actually make nursing decisions.

Nurse leaders of this country were meeting in this huge lecture theatre at Massey - Nan Kinross, Janet Quinlan, yourself, Yvonne Shadbolt, standing up and debating the way in which they had

reached the conclusions they had made – making decisions which had obviously impacted hugely on decisions that had been made in nursing education...It was interesting to see people who had been influential in the decisions about changes in nursing education being asked to defend rationale of how they reached those conclusions, and why they had impacted on nursing so significantly. That was quite significant for me...All of a sudden I became aware that there were people in our profession making decisions. Because up till then it had seemed that everything was cast ‘in law’ and I had never understood who was making those decisions...In school you were taught to follow whatever you were told, yet on the wards – without the knowledge you tried to make sense of what was happening and make decisions...So to see that modelled those years later by the Kuia of our profession...their ability to be decisive and clear and to have rationale and debate...and realise that you could challenge people. All of a sudden it was OK...to say to somebody – why on earth did you do that, do you think you really had the rationale for that, were we just following them like lemmings – the international trends - or did we have a rationale for our own context. And that is the debate I had - I recall the discussion vividly, but it was quite interesting all of a sudden it was OK to challenge and that seemed very liberating.

(Peach, 2:1-2)

Reflecting on decision-making changes over time Yvonne Shadbolt felt that for her the difference was when she recognised that decision-making was a process.

That it consists of various parts, and that it is possible to analyse that so that you can give full weight to all of the parts instead of responding perhaps intuitively or thoughtlessly to a part of the

context which has to be considered but is not the most important. [Using the example of calling the night supervisor], will she be mad if I call her is not a good or very important part of the decision-making, and I think if you can make a decision considering all the parts of the issue then that becomes irrelevant and you can say to yourself –well I think I should [call the supervisor] and if she is mad so what – because the decision to call her is not based on the fact that I’m anxious but that I’m anxious that this [problem] be attended to and I want it to be dealt with.

(Shadbolt, 2:2)

This reminded me of the interpretive process I was using to sift the source material in this account through the series of contrasts looking for patterns and trends. The importance of recognising skills associated with decision-making raises the question of the patterns, the hidden cues that emerge when the decision-making process is carefully thought through.

Offredy (1998), a UK nurse, writing about the application of decision-making concepts, identified the ability to recognise patterns (in clinical situations) to fit with patterns previously seen, as an important factor in decision-making. She also emphasised the importance of levels of practice and decision-making. This was described clearly by Yvonne Shadbolt who thought that the way in which she learnt to make decisions as a student nurse, and as a beginning nurse differed not at all from how she made decisions now, which involved this searching for cues and patterns.

I wondered whether it had changed really over time, and thought back to the way in which I made decisions as a student nurse and as a beginning nurse and I thought that it differs not at all from how I make decisions now. I mean you become more aware – you take notice of certain cues, you consciously or unconsciously

decide whether they need further attention and if they do you weigh up what it might mean and what actions may/should follow, and you act on that in the context...I can remember very early in my preliminary student days learning lots and lots about the various kinds of faeces and the colour of urine and the smell of breath and many things like that. These were all cues that you watched for and we used to observe body excretions with a great deal of concentration because from that you had to make some decisions about what you would do. Who you would tell, report to, what you would record about it, what it might mean, and so forth so in that sort of elementary way almost I think we built up a decision making pattern.

(Shadbolt, 2:1)

In addition to building up decision-making patterns, Mia Carroll believed that over time, confidence in the process of the quality of decision-making skills is the thing that alters.

The time in ICU was a confident time of decision-making for me because the way that you nurse in ICU means you get immediate feedback to the correctness [or otherwise] of your decision making. You knew if you diagnosed tamponade that within a few minutes you would be proved right or wrong and the parameters that were measured or articulated made your decision-making more transparent more quickly – it was easy...I still think I'm improving on my decision-making, I don't think its something that you stop – you just change...it is a process not an end point so the quality of my own decision-making varies...I don't think I've got an end point, when you don't reflect on it enough you think it's simple – but when you do you realise how complicated it is.

(Carroll, 2:2)

The impact of confidence in oneself and one's ability to make decisions is one of the key findings in this study. We begin with an ability to make decisions and as we learn, through seeing trends and patterns emerging, our confidence grows confidence as an individual nurse and of the profession as a whole. The nurses who made a difference were nurses who could make decisions, felt free to make decisions, and were confident in their own ability.

Jocelyn Peach spoke about this developing confidence. While mentioning decision-making responses linked to fear and being scared, she also outlined her experience over time seeing the real impact of a developing sense of confidence in the profession and the ability to make nursing decisions. The example she uses clearly highlights changes over the time period of this study. Jocelyn used the example of the Cartwright report (an inquiry into informed consent) referring to the nurses' decision-making in the 1960s that was mainly doctor directed and not really active on the part of the nurse. She contrasted that with what she observed at a 1998 inquiry where nurses' decision-making was again under question but this time was very obviously clearly thought about by the nursing staff before they responded. Jocelyn described the findings of the Cartwright inquiry as an important defining moment for her in relation to nurses' decision-making. The inquiry was about the lack of informed consent by women being treated for cervical cancer in the 1960s. Sylvia Cartwright, the presiding judge, described nurses as being 'less than brave' in their compliance with the system. (Note many 'nurses' in the 1960s were students not R.Ns).

I was in early days [late 1980s] in my life at corporate – the old 'Hospital Board' and reading with some despair the comments by Sylvia Cartwright about the issues – that stuff about nurses decision-making. To comply versus challenge – that wasn't in some ways an active decision...[In the 1998 inquiry] I stood tall

and cried actually at the recent inquiry. Some nurses, who were level four and in R.N educator positions, were put on the stand and grilled hugely about their decision to participate in that change in practice, [a form of physical therapy on the newborn]. Their ability to articulate their rationale for why they did it, they'd thought it through, they understood the anatomy and physiology, they'd made an active decision to participate because...they could see the bigger picture and they were prepared to be accountable. They felt tragic that the outcome had been as it was but they would do it again they said because this was the rationale for why, and 'we felt confident that we has the skills to do it'.

That was fascinating for me – to watch the difference in confidence – as a real partner in the decision-making process at the bedside, and in terms of changes in practice whereas before it was very much being what the doctor directed us to do. These nurses stood there and said – We didn't do so blindly, we did so having thought it through and worked our way through. It was stunning – they weren't handmaidens...It was almost like an evaluation of the professional development programme for me – it was like – all those years of doing this –it had come to fruition. I could tell that 'J' the nurse on the panel was surprised. I don't know if she thought it was good or bad – I can't judge that but I know that regardless of who judges that, the fact is that these were not handmaidens, they weren't hapless individuals just doing what they were told. These were thinking individuals who also made judgements and decisions about not proceeding for too long if they didn't feel it was in the babies best interests. [They were] assessing, making decisions daily, deciding if they would or wouldn't do it.

(Peach, 2:5-6)

This graphic example portrays for me the major change over time. The 'nurse' as unquestioning handmaiden doing just as she was told in the 1960s, through to the 1990s where the professional R.N is assessing and making judgements for which she will accept accountability, able to articulate the rationale for decisions, having thought through the situation. Nurses making decisions, making a difference.

Several participants raise the issue of the importance of the impact of the environmental context of their clinical practice on their decision-making ability. The opportunity to make decisions and assess their effectiveness. Just as ICU was the setting that enabled and encouraged decision-making for Mia, Lee Mathias found the renal dialysis unit and 1:1 care of a patient helped her clarify what decision-making was all about. Margaret Bazley realised that she learnt to make what she describes as 'crisp timely decisions' in her early days co-ordinating large numbers of psychiatric patients in one big area (outlined in 'vignette two' at the end of this chapter).

Marie Burgess found that her work as a public health nurse and as a midwife provided her with opportunity for independent practice and making decisions all the time. As a midwife in the hospital setting this opportunity was also available.

The decision-making the midwife did was pretty autonomous - again in terms of seeing people through, and monitoring, and making decisions about when to do examinations, and when to call people in...data collection on which to base decisions was clearer to me, particularly in midwifery.

(Burgess, 2:2)

Jocelyn Keith added another dimension to our understanding when she described the public expectation of the nurse in relation to decision-

making and our obligation to develop decision-making skills to meet this expectation, to get on with it, to make decisions and take action.

If you ask someone what they expect from the nurse they will expect wise advice, and they will expect prompt action. They expect you to roll up your sleeves and get on with something. They expect you to be slightly bossy about what they should do or what they should not do, but you will make up your mind, you will make a decision with them and for them –you won't 'shilly shally' around ... It's a feature of the public expectation of us and I think for that reason alone, we have an obligation to make sure that nurses develop decision-making skills.

(Keith, 2:5)

The above accounts from the participants have demonstrated the attitudes and beliefs they perceive influenced their decision-making. They learned to make decisions as children and continued to do so throughout their lives. They learned through study, experience, by recognising cues and patterns, by careful thought and reflection. They explored the process of decision-making and they developed confidence in their ability through their experiences enabling them effecting change in a variety of fields of nursing, exhibiting primacy.

The next section explores how through their own understandings of the importance of the ability to make decisions the participants assisted and supported others develop a decision-making response.

How did the participants support others to develop a decision-making response?

The provision of support for others in assisting them to make decisions reflected the participants' careers and roles over time. The significance of decision-making was so pervasive that on reflection nearly all the

participants had some memories of how they assisted others to develop decision-making abilities. The processes the oral history participants used included encouraging others to value their contribution, to focus on outcomes, to take space and time to reflect, and by acting as mentors, teachers, and role models.

Jocelyn Keith as teacher, had put together a kit-set of work looking at decision-making when she was asked to speak to nurses studying at Victoria University of Wellington. The kit was entitled 'How do I get street wise?'

I put together a little kit that explains some of the 'Getting to Yes' [a book referred to earlier] thinking about how decisions are made, how decisions are made in public policy. Some of the opportunities there are for comments on public policy, such as writing submissions, what a submission looks like, how you present it, how you evaluate it – so it's a little kit-set of work looking at decision-making. In addition ...I sometimes include in my pamphlet information [from previous work] using the categories of 'voice'...all about having your say, knowing the language, having a place, having an advocate, not being shouted down, having your contribution valued.

(Keith, 2:4)

The question of having your nursing input valued was raised several times mainly in relation to a sense of confidence, the ability to advocate for and about nurses and nursing. The development of the profession and individual 'professionhood' is demonstrated through the contributions made and valued by the patient, their family, and other members of the health care team.

What Jocelyn Peach said she had realised over time, was that the support she offered was related to the need to encourage and liberate in others that ability to make decisions regarding their practice.

So a lot of what I've done, as a charge nurse and in professional development leadership roles, what I've sought to do was to develop the potential of nurses to make the kind of decisions ... to learn the structures and the frameworks and gain confidence ... so you end up with nurses at level three and four anticipating and preventing problems and providing rationale and enhancing their credibility with the medical staff as things have become much more complex in clinical practice and that was a big issue for me.

(Peach, 2:4)

This level of decision-making was at a professional level and enhanced and made explicit the nursing perspective as opposed to the contribution from other health care professionals. Yvonne Shadbolt described her role as a teacher as focusing on helping students to establish a framework to see themselves becoming a nurse, and what that would mean, because that would be the context in which their learning would take place from then on. Students needed to know about 'nursing', 'nursing decisions', and the professional responsibilities of being a nurse, and how the nurse fitted into the system.

I was also quite anxious to have the students understand that all decisions come about as a process and that with ethical decision making in particular, making appropriate decisions would/could be improved if you really understand the process whereby you came to them...I think that one of the things that is difficult for students, it certainly was for me, is that the decision-making process was never visible.

It never occurred to me to ask someone why they had made that decision rather than another and what would be the ethical context. That was a hidden process ... I really tried to encourage people to ask others what/how they'd reached that decision or that position.

(Shadbolt, 2:3-2:4)

The invisibility of decision-making mentioned by Yvonne in learning the 'how' of decision-making needs to be made more visible so we can explore the process, and debate and reflect on the outcome of our decision and why we made the decision in the first place. Was it the best most effective decision? What can we learn from the process?

Mia Carroll mentioned two strategies she used to assist others with decision-making. The first was a strategy to assist individuals by using ethical analysis. The second was an organisational strategy where members of the senior nursing team utilised critical reflection of nursing research literature.

One of the things that I am constantly trying to do now is to identify with and for people, the influences on decision-making. I teach ethical analysis using David Seedhouse's framework and I talk to them about how when you don't take space to reflect on what's happening then you can't see all of those influences on your decision. When you don't take space to actually hold for a minute, the quality of your decision-making is maybe more acute but may not be better...We're teaching critical analysis [to nursing staff] – critical reflection on the literature – we're moving towards evidenced based practice and therefore understanding systematic reviews whereby we can become more critical of the influences that either make or break our decision-making.

I think we are teaching more about the process of reflection so that people can understand what influences their own decision-making.
(Carroll, 2:3)

Critical reflection enables us to continue to grow – to move forward individually and as a profession. While Jocelyn Peach and Mia Carroll described their perception of how they encouraged and supported others to make decisions, Margaret Bazley led by example and her expectation that others would make the decisions they need to make as part of their role was made very clear to those with whom she worked. Her reference to the need for ‘crisp timely decisions’, and the effort she made to make decisions with minimal delay is an important lesson for us all, and are detailed in her vignette at the end of the chapter.

Lee Mathias also talked about leading by example, as well as teaching and challenging. Teaching decision-making involved not only the teaching of the nursing process in the classroom but the introduction of primary nursing was built around individual nurses’ decision-making skills. Over this period in the 1970s and 1980s there were times of intense frustration for Lee when she could see the potential that was not always achieved. The opportunity to challenge others, to motivate others was another strategy she used (refer to her vignette at the end of the chapter).

Despite the positive processes described in this section that were used to enhance decision-making skills in others, several of the participants expressed their frustration with colleagues who were either unwilling or unable to make decisions. Nurses in this position create a barrier for themselves and the profession. An inability or lack of willingness to move forward, can retard professional growth. Sally Shaw and Jocelyn Peach provide examples of this impediment to nurses and nursing as a whole.

Jocelyn Peach as a leader within the Nurse Executives of New Zealand group described situations in the 1990s where she has been brought into a setting that has been poorly led - where there has been no progress.

I've seen examples of people who won't make decisions and I've picked up the pieces...I've been sent in to fix problems – investigate and 'fix' problems and I've taken over from people where decisions weren't being made. The effect on morale – the frustration, the hopelessness that evolved is just...I've almost ended up sort of triaging. Here's an issue - OK let's work through the issue, there's a decision, let's go. The change and impact you can see in terms of people's motivation and their feeling of energy is just stunning.

(Peach, 2:8)

Both Sally Shaw and Margaret Bazley have held the highest status position in nursing in New Zealand – the most senior nurse in the Department (now Ministry) of Health. They had both been involved in times of turbulence and rapid change, and I believe this experience emphasised for them both the importance of decision-making. Sally like Margaret was clear, that if you couldn't make a decision, the outcome has the potential to endanger people at all levels.

You have to be able to make choices – which is a decision. You have to be able to assess a wide variety of information, analyse it and come to some conclusion about it. Whether it's direct nursing care and whether you are a student nurse in that situation or whether you are at a 'higher level' in terms of policy – Chief nurse or whatever.

(Shaw, 2:1)

Sally also described the difficulties she sometimes experienced when decisions need to be made and others can't or aren't prepared to do it. By

focusing on outcomes rather than process this led to a greater 'degree of comfort' for her.

You feel the need to make decisions because others won't, or because you believe it's the right thing to do, or you believe you have to take a different direction and other people aren't prepared to do it...It's only in recent years that I've really developed a sense of comfort in other people that worked 'for' me making decisions that might be different from what mine were, of doing things differently but focusing on the outcome rather than the process. I think in the early days when you take on positions of responsibility you're a bit hung up with process 'cos that's the way you're taught. [You] had the procedure books, and rules and regulations but later there comes a greater degree of comfort...worrying less about the process in some things. Don't get me wrong – I think process is enormously important and can often lead to outcomes, but giving people the real freedom to do things their way so long as that was reasonable and that the outcome really what mattered.

(Shaw, 2:3)

I have personally found the idea of gradually developing a 'degree of comfort' very helpful when assisting people to learn how to delegate, especially in areas where they believe they have considerable expertise.

Jocelyn Peach discussed the importance of a mentoring role for level three and level four nurses and the feedback she gets about her ability as a coach to be prepared to assist people make a decision.

People give me feedback that they find that [ability to make a decision] reassuring. They'll come to me with an issue and very quickly we'll have a clear way of working through it and come to a resolution and make a decision...What I do is help them understand a range of options and let them make a choice.

I don't make decisions for people but I'll say – so let's explore what's possible and you choose from this whatever and we'll support whatever decisions you make. But let's make sure that you're informed in the decisions you're making. So it's very much that stuff – I learnt a lot from Cartwright – that stuff in the Cartwright about decision-making and informed consent, and making sure that people had all the information they needed to make decisions. I think I always knew that but it was like a defining moment again of understanding of my responsibility to do that at all levels. Not only with patients, but also with nurses.

(Peach, 2:9)

Evidence that nurses had indeed learned to explore and write about their decision-making in the 1990s was demonstrated by the individual portfolios they presented as evidence in assisting them go through the process of meeting the requirements of a clinical career path and moving from one level of practice to a more experienced level.

NZNO developed a professional portfolio in 1998, to assist members put their individual portfolios together, and in the section headed 'professional performance assessment' exemplar writing is included to encourage the process of reflective practice, and "facilitate lines of inquiry and research questions raised by your own clinical knowledge" (NZNO, 1998, p.6).

The oral history participants provided a range of processes and opportunities they saw as helpful in gaining insight themselves into how decision-making is learned, and how be working with others we can teach others to make decisions and move froward. They were very clear about the possibilities of learning to make effective decisions at any time that at some point we realise we can and should make nursing decisions, that we are free to make nursing decisions, and that we can begin to act – to bring

about positive change. The strategies they used to help others learn included encouraging nurses to value their nursing input, to develop confidence, to be clear about the concepts of nursing and nursing decisions, to focus on outcomes, to take space and time to reflect on the 'how' and be acting as mentors, teachers and role models.

Most of the strategies they used were not found in written texts, but evolved through their own experiences, illustrating again how we can learn from the past to inform our present, and value the importance of decision-making. If we are to continue to make a difference and to move forward positively, it is no longer appropriate for nurses to be unable or unwilling to be responsible for nursing decisions. The primacy of the nurse is dependent in the first instance on effective decision-making ability.

The next section, the participant vignettes, pulls together an individual perspective within a context, to gain a sense of the whole. The 'what', the 'why', and the 'how' of decision-making. The section provides a perspective on two individual participants, Lee Mathias, and Margaret Bazley and their way of thinking, perceiving, and responding to the importance of decision-making over time.

Participant vignettes.

The two vignettes provide an opportunity to explore two accounts through the thoughts, reflections and insights that reveal more about who these nurses were, how they thought about their world, and their way of being in the world. The vignettes revealed the processes and influences that impacted on the understanding of the why and the how of decision-making and an insight into the importance of decision-making within the context of their work.

Lee Mathias provides an exploration of the process of personal decision-making and its significance to the individual and the profession as a whole, while Margaret Bazley shows an emerging clarity of the significance of decision-making within an organisational context.

Vignette One: (Lee Mathias)

This vignette is an exploration of ‘nursing decisions’, the journey of how Lee learned to make nursing decisions in an environment that supported and encouraged such development, and how she shared and continues to share that knowledge in assisting others to develop this key skill.

Lee registered as a nurse in 1972 and after working as a staff nurse she went overseas, as many nurses did at that time, working in England where she gained a Certificate in renal diseases while working in a renal dialysis unit. On her return to New Zealand she spent time as a staff nurse, a nurse tutor, and then moved into a senior supervisory role – the first such nursing management position. She began a Bachelor degree programme at Massey University including nursing studies and economics. Lee was one of many nurses thinking about how they were ‘doing nursing’ in the changing environment in the 1970s. In her position as Senior Supervisor in a major hospital she introduced primary nursing – a huge change for the Registered Nurse used to administration rather than bedside nursing, and over this time spent a lot of time teaching nurses the ‘how’ of decision making. Maintaining a clear focus on the changing socio-political context and recognising that a key structural framework for the future would be in general management, Lee completed an MBA in the mid 1980s. In 1984 Lee then moved into nursing administration and later became the Principal Nurse at a large metropolitan hospital. Throughout the late 1970s and 1980s Lee was an active member of the NZNA and in 1986-7 was President of the Auckland Branch. In 1990 with restructuring creating Area Health Boards, Lee was appointed as Director of Nursing and

Clinical Support Services, choosing the latter to maintain a breadth of practice. During this time Lee completed a certificate in economics to keep up to date. In 1993 Lee was appointed as general manager of strategic planning for Auckland Health Care over a time that was a high learning curve for everyone in health administration. Lee left in 1994 and started work as a consultant in general health care, able to move across a wide range of issues. While continuing to undertake some consultancy and contract work Lee currently manages her own small private maternity hospitals, and is a Director of two Crown Health Enterprises, and the Accident Compensation Corporation (ACC).

Common patterns mentioned by other participants include the focus of her initial 'training' on rules and protocols; the influence of working in a practice context that encouraged autonomous decision-making; the impact of post registration education; the importance of a sense of self confidence; and a willingness to change and be flexible.

Lee 'trained' through a system based on rules, clear policies and procedures, as someone who had taken direction until well in her third year as a student even though she did 'charge' and ran the ward on some duties but this was run '*according to protocols*'

In her 'staffing year' (first year as a Registered Nurse) Lee was exposed to nurse 'A'.

She was an 'old school type', who didn't take on the new thinking at all but almost innately [in the way she practised] she had an authority within her practice that [led to] other people letting her make decisions ...This was reinforced by the two senior medical staff at the time who had quite a clear picture about what their role was, and what the nursing role was – so I watched that happen.

Then when I started to work in a team there was an expectation that I would make the nursing decisions. Now that came from senior medical staff (in the renal and general medical area). Nurse 'A' exposed you to situations where you did work on your own and you did have to function relatively autonomously. A lot of that was to do with the technical procedures involved but you would be left on your own for eight hours to manage a dialysis. You might not see anyone else for eight hours...the force of the environment meant you had to learn to make those decisions.

(Mathias, 2:1)

The fact that senior medical staff were very clear about the nursing sphere of practice and reinforced that nurses made the decisions about patients mobility, care of the skin and so on, assisted her ability to learn to make effective nursing decisions.

I was very lucky because I had a daily framework that was reinforced by the rest of the team. Not many nurses I think had much of that. I suppose that today the younger medical set does support this because they know their technical skills are no good. In areas like CCU, dialysis, the doctor prescribes the treatment regime and things but it is the nurse who is making most of the decisions about what physically and emotionally happens to the patient and they are left to it.

(Mathias, 2:2)

While being encouraged and supported to make decisions, Lee felt that in terms of knowing what specifically was a 'nursing decision' that didn't really come until she did academic study in the mid 1970s. This enabled her to put theoretical concepts into practice and test out ideas. Guided by a nurse educator (Norma Chick) who could certainly identify what was a

nursing decision, Lee was exposed to mainly American nurse theorists like Callister Roy and Dorothea Orem who

influenced me a lot. All that self care stuff – where you actually have to identify quite clearly what the nursing role is in relation to whether the patient can actually do it themselves...a whole list of decisions that were made by the nurse or the patient – you had to separate them out.

(Mathias, 2:2)

Lee thought that her academic study was the major influence in her own decision-making ability

The main thing was academically – clearly able to define ... what nursing was and so therefore being able to say this is what it [a nursing decision] is and this is what it isn't. This is the decision that can be made by nurses and this is the decision that can be made by anybody else. Now in the late 1990s that is becoming a bit more blurred. [We have] a multiskilled workforce so we're talking more about 'patient care decisions' as against 'nursing care decisions', and I must admit that it is the midwives and nurses who are almost moving back to that multiskilled health professional...So what is happening I think is that in most of the major public [health] services in particular you get that strip of professional allied staff at a high level, who do specialised things but the nursing staff doing all the other. So their role is even more comprehensive which is allowing them to focus their decision-making again on the whole patient – they are not actually confined by having to wait for – or fit in with the decision-making of other groups.

(Mathias, 2:1)

Lee expressed her belief that each individual nurse needed to develop confidence not only in decision-making, but also in an ability to place an argument.

I want them to have exercised and reinforced their academic learning and sometimes those two are a little bit too far apart. I know I have had students who in class can give me amazing feedback on how they think and how decisions are made and you go into their clinical area and they're functioning somewhere in the 1980s. I say 'why are you behaving like this? [And the answers include] ' Because that's the particular ward I work in and she (the charge nurse or whoever it is) likes things done this way', and you say 'well haven't you challenged that?' 'OOOH no I haven't challenged that. I'm too...Again it is that confidence thing – the confidence in your own competence –[The confidence that] my decision is actually right, and I can argue that it's right and I have the confidence to actually convince somebody else that it's right.

(Mathias, 2:12)

As Lee learned through study and a supportive clinical environment, she gained confidence in her ability. She emphasised the ongoing importance of this self-confidence in being able to make decisions and move forward.

Part of our growth as individuals and for the profession as a whole, is dependent on our willingness to change and be flexible. Lee spoke of the need for all of us to support and encourage the young, the new graduates. She is disappointed that in some environments we fail to do this.

I get very disappointed when I see bright young sparks – rising stars and they just get cut down because of very petty things ... We're not as a group as sophisticated as we could be in terms of encouraging our young, our tall poppies...One of the environments I'm working in at the moment is like that [not supporting the young] the difference between how another particular operation I'm involved in runs, and this is like chalk and cheese.

You wouldn't believe we came from the same professional backgrounds – just in the whole attitude to life, in terms of the nurses celebration of life.

(Mathias, 2:10)

This ability to change, be flexible, support and encourage others, can be linked to the idea mentioned earlier about the boundaries of 'what is nursing'. Over time this question of what is nursing has created tensions between nurses, managers, and other health professionals. Lee felt very strongly that we need to take the 'opportunity to nurse' wherever and whenever the occasion arose.

*[In the early 1980s] there was the great move away from non-nursing duties, and to a certain extent I personally felt that was a bit negative for nursing. It had a bit of a negative impact. Some of it [this move] was to do with resource issues because it was when we started the huge reductions in funding...So nurses were effected in the amount of resource that they had available to them and so they started saying **no**. We're not going to take on another job because it is 'non-nursing'. That was their excuse but it was really because they actually didn't have the resource to do it...That meant that nurses started saying they wouldn't take on tasks or do tasks which would have otherwise given them an opportunity to*

nurse. I can remember having great arguments in 1983-4 about phlebotomy. You'd say to nurses 'but hold on all you're doing is sticking a needle in, getting some blood off very like a whole host of other activities that you do and which you call 'nursing'. [they would reply] 'Oh it's not nursing' [and my response would be] 'But it gives you the opportunity to nurse, it gives you the opportunity to interact with the patient. I can remember spending hours debating that sort of example.

(Mathias, 1:3)

With clear ideas about what nursing is all about, the importance of being able to articulate how and why nurses respond in a particular way, Lee has worked hard as a role model and teacher to instil self-confidence and clarity of decision-making in those she works alongside.

In exploring how Lee supported and influenced others to develop nursing decision making skills she talked about leading by example, teaching and challenging. Leading by example was an important part of her role as a supervisor and more recently as a consultant. Imbedded into her management style was the expectation that nurses will actually practice at a certain level.

There were times of intense frustration for Lee when she could see the potential that was not always achieved and so the opportunity to challenge others, to motivate was another strategy.

[I used] a lot more challenge than I probably care to admit [I was] a lot more demanding...I remember losing my temper at people who didn't have the confidence to make decisions themselves. I can distinctly remember a particular staff nurse (now a very senior person) and dragging her into my office, sitting her down and

saying, 'This is what the patient's problem is about. This is the range of interventions.! These are the choices you've got. What is your choice?' Then by a process of exclusion she came to the answer – and I said 'well you did that –you did it easily, why did I have to sit you down to do it. Come on you are a bright person - have some confidence.

(Mathias, 2:2)

The need for each nurse to be confident in their ability to assess, to make decisions, and to act upon them is clear when considering the nurse as part of a team. When Lee was out in the community with other health professionals and decision-makers telling them about the potential of the nurse, she needed the nurse to believe in herself too.

[For me it was about] I'm going to get you [the nurse] into a position to make this [nursing decision] because I'm making claims out there that you can do this and just because I think I can do it, I believe you should be able to do it too.

(Mathias, 2:3)

In the late 1990s, we are talking more about 'patient care decisions' than 'nursing decisions'. With a multiskilled workforce the focus of decision making needs to be on the whole patient not confined to waiting for, or fitting in, with decision making of other groups. Lee outlined the importance for her of each individual nurse being able to think critically about each patient and not relying on standard care plans or medical diagnoses. A senior medical academic had recently shown Lee a research paper that found that up to 60% of provisional medical diagnoses had nothing to do with the final medical diagnosis. She suggested that if this is the case and if nurses build a lot of their care around the medical diagnosis, we need to consider very carefully the implications for nurses' decision making and the way we move forward.

One of the most influential ways Lee felt she could support others was helping nurses see where they fit in the big scheme of things. How important they are and can be in contributing to the health of New Zealanders.

I'd like them to see that bigger picture – not only in the health sector but from a broader sociological context ... You know that group that come to work, do their job, go home. You know they function OK at work and that they are nice, nice to the patients, and they make reasonable decisions...but they really have very little understanding about where they fit in the scheme of things and yet it is quite an important part in the health sector. It is probably the most important role.

(Mathias, 2:12)

In the final analysis though it all comes back to confidence. Lee is often asked for career advice, especially from nurses interested in management. After discussing the kind of experience and education that might be helpful, she returns to the key attitudes – confidence and self-belief.

*You'll need to have Masters level preparation and Masters level preparation in management – but the key thing you need to be able to do is **exude** confidence whether what your telling fits or not. Of course you need some integrity, but you've actually got to be able to stand up there and demonstrate it – be enthusiastic about it. The people you are talking to are smart, they are intelligent, you can't get away with skimming the surface. You've actually got to know what you're talking about.*

(Mathias, 2:11)

Lee is a nurse who has made a difference. Her attitudes include self-confidence, a willingness to change and be flexible, and to support and encourage the new graduate. Taking every 'opportunity to nurse', to interact with the patient, is also an important attitude that assists both the growth of the individual and the profession.

Vignette two: (Margaret Bazley)

The second vignette is a broader approach outlining how Margaret developed an understanding of the significance of decision making in the management of her work and how she critically reappraised the impact of 'crisp timely decision making' over many years. The importance of decision-making by those in leadership positions is very clear in this example.

Margaret began nursing as a student in a psychiatric programme, and aware of changing attitudes to mental health she subsequently completed a programme as a general and obstetric nurse with a one-year concession. Her work during the 1960s was in Psychiatric Hospitals, as a Ward sister, Assistant Matron and then Matron. She completed a Diploma in nursing from the New Zealand Post Graduate School in 1965 starting in the Nursing Administration stream and then transferring to the Nursing Education stream when targeted by the hierarchy in the Department of Health to teach a six month course in Psychiatric nursing to Registered General Nurses on completion of the Diploma programme.

Changing priorities meant that Margaret was redirected to a position as Matron of a major Psychiatric Hospital where there was a need for innovative change and Margaret was thought to be the one to assist achieve this. At this time there were very few nurses qualified in both areas of general/obstetric and psychiatric nursing and Margaret's expertise was in demand by nursing organisations that needed a psychosocial perspective. Margaret was nominated by NZNA as their psychiatric nurse

representative on the then Nurses and Midwives Board and was on a number of nursing committees during this time. She became the President of the NZNA in 1972, the first person with a psychiatric qualification to be elected and used her leadership and decision making skills to focus on enrolling nurses to support the transfer of nursing education. Her skills now greatly admired Margaret became a Senior Public Health nurse in 1973, was appointed Deputy Chief Nurse in Auckland in 1974, and in 1975 Chief Nurse with the Waikato Hospital Board. .

In 1978 Margaret was appointed to the Director Division of Nursing in the Department of Health (the most senior nursing position in the country) and she left this position to take up an appointment as a State service commissioner – the first woman to be so appointed. Her career then moved into the broader areas of the public service as CEO of the Ministry of Transport in 1988, and subsequently in 1993 as CEO in the Ministry of Social Welfare.

Margaret's contribution is one that highlights for her the significance of decision making as a key ongoing skill in management. At the time of our second interview she had just started to work with NZ archives on an oral history covering her contribution as a senior woman in the public service. This meant that some of her ideas had been recently thought through including the impact of her management style, and how she learned to make decisions. Margaret has never forgotten the skills and lessons learned as a nurse and often acknowledges this when she speaks to the public.

Common patterns mentioned by other participants include the influence of the practice context (her early days as a psychiatric nurse); the effect on organisations if decisions are not made, and the importance of continuing to learn, reflect and re-appraise progress.

Additional points made by Margaret include the importance of ‘courage’ for making decisions. Courage to change a bad decision, and the importance of the pace of decision-making, the pace that leaders set dictating the whole pace of the organisation. Margaret also spoke of her ability to have a vision – a sense of the future.

The impact of the significance of nurses development of a decision-making skill began with her experience as a student psychiatric nurse at the age of eighteen working in the Auckland Mental Hospital later known as Oakley hospital in an area known as the ‘Court’.

They had the most dangerous women from the whole country in there...300 of them in these two wards and during the day they used to be in the ‘Court’ there would be all these people and 13 nurses. The whole thing was driven by meal times – you had to have the full complement of nurses to feed the patients because it was such a dangerous time. You had everyone with knives and forks all together and hot food and plates and the nurses couldn’t go to a meal until the patients were fed and the cutlery all put away and counted and locked up...The nurses had to go to two meals –you really couldn’t get any slippage you know and so if you didn’t manage you would be in big big trouble – you can imagine the potential, so I realised that that’s where I learned to manage. By the time I was 19 years old I was in charge of that court and I actually did about 13 months of my three year training in that job. You had to have skills - a lot of nurses couldn’t do it because they ruffled the patients so I must have learned to manage in an orderly calm way. To do things like keeping order, meeting deadlines, dealing with crises and I’d never really thought before but that’s where I learned to do it.

(Bazley, 2:1)

As we explored the concept further, Margaret agreed that the theme of decision making was important for every aspect of management – a recent experience in her own department had reinforced yet again the problem that presents and how the whole organisation can be affected through in effective decision-making.

If you've got someone in a leadership position who can't make crisp timely decisions - it affects the whole tone of the organisation and you can't have that in nursing. You know where you are dealing with life and death situations, decisions have to be made.

(Bazley, 2:2)

Margaret acknowledged the importance of continuing to learn and to reappraise where you were at, and that there were several times in her life when she re-looked at how she acted how she had made decisions She spoke of the excitement and intellectual stimulus of making decisions relating to problems –

I always have ten-year strategies and focus on big outcomes...I spent hours working out my strategies you know and that's problem solving – working out how you can actually do it. So it's using the problem solving technique - it seems like cleaning a dirty house – you get it all in order and then you move on.

(Bazley, 2:7).

Margaret continued learning about the significance of decision-making throughout her career. At times in her life she not only rethought her vision, but also the strategies she used, including having the courage to change a bad decision.

I think at various points I've realised I've reappraised that [making decisions]. There are some times, I remember when I was Matron at Sunnyside [a Psychiatric hospital in the South Island] changing a decision. Some of the older men said 'Oh you can't do that – you've made your decision' and I said to them, 'No if it's the wrong decision – I'm better to change it' - and we had quite a debate. I remember that that was when I had quite a good look at it [decision-making] in fact I realised then that you have to have courage. Courage to go back and change a bad decision. It's not that you don't change it – and I realise that people who don't change very often don't because they don't have the courage to do it – so I remember doing quite an appraisal then

(Bazley, 2:2)

The importance of those on leadership positions making 'crisp timely decisions' and enabling their organisation to move forward was a lesson learned over time. Margaret talked about the lessons learned from Margaret Millar (the Chief Nurse of the Auckland Hospital Board when Margaret Bazley was her deputy). Margaret Millar had emphasised the importance for her of not going home at night without answering everything that had come into her in tray – Margaret Bazley had always endeavoured to work to that rule because she realised how this effects the pace at which decisions can be made throughout the organisation.

I learned later on – particularly since I've been the head of a big organisation that the pace at which a Chief Executive pushes through their in tray dictates the whole pace of the organisation...I've developed some rules for myself over the years – that if I see something and I know that I've got to give more

thought to it – I always make sure that I get right back to it – that I don't put it at the bottom of the tray – the too hard basket. I've probably disciplined myself a lot more in later years to just get straight back to those things...I try not to have people hanging around. There are sometimes I need to have people in to give me more briefing – sometimes I need a few hours to think through a difficult [decision] - but I always try to make a decision as quickly as I can because I realise that my not doing that has a big impact on people all the way down. It holds up their work and costs the tax payer money and so I certainly do see decision making as being quite key.

(Bazley, 2:3)

Effective decision-making is not carried out in a vacuum. Decisions need to be made within an environmental context with some purpose in mind. For Margaret this is all about having a vision. A vision of how she would like the future to be and then a commitment to move forward to make that vision a reality. By the time she had left Oakley she had developed a burning vision that things could be different through her reading and talking to others

I knew I had a vision of what it could be like and that I realised that that's the thing I've probably brought right through my career - and right now. I'm having a battle 'cos I've always had a vision and it's always been into the future and I'm absolutely committed to it. There are always a hell of a lot of people who want the here and now – who are frightened by any change. So when I look back...I could almost tell you the major battles – I'm having one right now on Technology...I always do a lot of talking around getting that vision - of knowing where I've got to go, but once I've got it clear...I don't go off on tangents. I never give up.

(Bazley, 2:6).

As well as being prepared through experience and academic study, being willing to grasp the opportunity if you have the ability enables personal professional growth. Margaret believed personally that she was very fortunate to live in the times she did, being there when they started to appoint women to senior positions in the public service.

I think that a lot of women thought that just by being a woman – when the world started to change that you would just get promoted. They didn't see that in fact it wasn't enough to just go off and do some study. You actually had to have some experience as well – so it is having the two things [ability and grasping the opportunity].

(Bazley, 2:9)

Recognising that seizing opportunities to make a vision a reality you needed to enrol others. Margaret supported and helped others recognise the importance of decision-making by her role modelling and by being very clear about her expectations. She also believed that it was important to provide people with opportunity and that is her role to take a lead and 'create the space' for others to follow.

Everyone who works with me knows that I don't tolerate indecision. I've actually had a general manager recently who was not too good on decision making – I used to get him over and I made sure that the [necessary] decisions were made. I have a very strict follow up system to ensure that any work I am involved with

*that involves other people making decisions that they know – I think all my staff know, that if they get anything from me it has to be turned around quickly and that I expect decisions to be made. They know that if I ever find that something has sat around (sometimes I get a letter from the public to say – you know ‘I wrote 6 months ago’) and people know they are in big **big** trouble if that ever happens.*

(Bazley, 2:3).

In addition to ‘creating space’, Margaret believed that leadership is about creating the right environment. It is not about grabbing power and control. It is all about giving people the freedom and support when they get stuck - to get in and fight their battles for them, to clear the way. Margaret also believes that as work can be pretty boring, people enjoy stimulus and want to be part of an environment that makes things happen.

I work on the principle that people like stimulus. The work and the excitement and watching the results because you don’t do it yourself. It is really creating – creating the environment where good people see that there’s a lot of excitement and they want to be part of it. It’s no good being there [in a senior position] if you don’t deliver. You have to have the ability to...make it move along...I’ve always worked very hard and I know that an organisation can only go as fast as I go – so I go as fast as possible. Staff over the years always moan like mad that I work them too hard but they always tell me at the end and afterwards that it was the best time of their lives. I work on the principle that people like stimulus and the excitement. You don’t do it yourself, it’s really creating the environment...I provide the environment I always seem to give them the freedom and to give them the support when they get stuck. To get in there and fight the battles for them,

to clear the way to drive things for them ... One of the women said to me that the reason she liked working with me was because I was always out in front - forging the way ahead and she was able to come along behind and that she was able to get on – she had the freedom [to act].

(Bazley, 2:9 – 2:10)

Like Lee, Margaret also sought to provide opportunity for the young

I've always been a great believer in giving young people opportunity because I always thought that that is how people can really develop and learn, and I probably learned a lot of my courage for making decisions [when I was young] because again I think you can't get that courage the same when you are older.

(Bazley, 2:2)

Margaret was positive about the abilities of the individual nurse and that if they set their mind to it – the sky is the limit.

Nurses can do anything if you set your mind to it you know. The sky is the limit ... you know nurses are good managers, good teachers, and there aren't a lot of people in this world who have those skills...I'm very involved with the selection of top public servants – there are lots of people with PhD's and all sorts of qualifications, but there aren't too many people who can actually manage 3000 staff and get an outfit performing. I believe nurses do have those ... Nurses do have the management ability and so they can do anything if they are so inclined and if there are opportunities and they have the ability.

(Bazley, 2:9)

Margaret is another nurse who has made a significant contribution.

Her attitudes included seizing opportunities as they arose, commitment to a purpose and vision, courage, persistence and resilience. Beliefs included the need for a clear vision to guide decisions, the importance of creating space, creating a supportive environment that gives people freedom and that for the individual nurse, the sky is the limit.

Margaret's responses focused on crisp timely decision-making that ensures the pace of organisational change is progressive. She emphasised the need to learn for the past, and having the courage to change a decision if it seem wrong. To clearly define a vision and reflect on future strategies which included enrolling and working with others towards the common vision. To learn from the past, use that knowledge in the present, and consider possibilities for the future.

Concluding remarks.

In the first theme, square one on the surface of the quilt I have explored the critical concept of decision-making in relation to the primacy of the nurse. In considering how decision-making over time contributes to the concept of the primacy of the nurse in New Zealand, the reader can examine the movement and influence of the individual nurse and the profession over four decades. We can also examine the dilemmas and struggles over time as nurses and nursing faced challenges, worked proactively and strived to make things better for the profession. This was either in response to events or changes that nurses needed to be part of – to react to – or as a response to what could be seen as visions or possibilities in and for our future. Globally throughout our history members of the profession have always responded. Nurses have always made decisions, and nurses individually and collectively have made progress mainly when they have been actively responsive to the needs of

the day in the sense of being clear about our direction and what is needed to guide the response.

Decision-making is a key characteristic in the concept of the primacy of the nurse. This is particularly so in the case of ‘nursing’ decisions. Decision-making is about making judgements, being responsive to situations. It is the process required before we can do or achieve anything. Nursing decisions are the prerogative of the nurse, and we must accept our professional responsibility for such decisions. If we abdicate our responsibility for nursing decisions, it is possible that others will dictate our responses.

From both the written and oral texts it is clear that nurses have made some major decisions in each of the four decades in response to challenges in nursing education, nursing practice, and nursing regulation. This responsiveness has been by individuals, small groups, and organisations, in all manner of situations. It has been equally important in ‘little picture’ situations as in the ‘big picture’ situations. Confidence in an ability to make these decisions, and persisting until the task was done were a crucial aspect of this responsiveness, as nurses acted to change, to build, to create, to support, and to promote their contribution to the health of the peoples of New Zealand.

What is particularly interesting to note is that both national and international written texts provide the reader with information about what happened during these four decades, and sometimes why it happened, but very little about **how** it happened or the stories that underpin the struggles and diversity of views about why and how we were to move forward and progress as a profession in relation to any particular issue. It was in the oral histories that such details emerge. The contrasting views, the resistance to change, the stories about whom the major players were in a

particular issue, or how different groups worked or failed to work together.

Over the four decades the mantle of decision-making shifted. It shifted from the very few in positions of authority that had ‘positional power’ in the 1960s, and chose – or did not choose – to make decisions. In the 1970s, decision-makers included those who had travelled and come back to implement change or ‘spread the word’, those with higher education, or those who had a particular purpose. In the 1980s decision-makers included leaders in education and clinical practice as well as those in administration who could make decisions locally. In the 1990s decision-making was expected of every nurse, clearly demonstrating the primacy of the nurse.

Cultural shifts in the nature of decision-making and the freedoms to make decisions are also clear over the decades. The nature of decision-making evolved from the externally generated rules and procedure driven practices in the 1960s, to the individual nurse using her professional judgement in each situation in the 1990s. The pattern and trends seen over the decades demonstrate the importance of decision making in relation to our development as individuals, and for the profession as a whole. We learned who could make decisions, how to make decisions, when we should or could make decisions, and these expectations impacted on every aspect of our professional life – including our freedom as individuals to grow professionally.

This increasing freedom opens up future possibilities and a growing sense of hope that our decision-making will become increasingly sophisticated in developing educational frameworks and models of practice, and will enhance our participation in policy and legislative decisions.

What stands out from the oral history participants and the literature is the significance of coming to understand that decision-making could be

learned, and understanding the 'how' of it. The participants also revealed the process by which nurses have come to really grasp that the possibility - the freedom to make decisions, exists - and how to use this across a range of practices.

Recognising that attitudes and beliefs underpin our responses the participants made it clear what attitudes and beliefs might assist the nurse to make decisions, to progress as individuals and as a profession, regardless of the setting or size of the issue. The importance of building on confidence to go ahead and make changes was revealed as the participants gained skills and moved from little decisions to bigger decisions in their own lives - developing a personal sense of confidence – knowing that you can be effective and then having the courage to make decisions, to take a risk. They highlighted the importance for us all of small successes to boost our growing sense of confidence, and how this can be enhanced by a positive attitude to change, a 'can do it attitude'.

The participants' accounts also demonstrated a sense of passing on the mantle as they assisted and supported younger nurses. Having gained skills themselves in a variety of ways, they seemed to value mentoring others to gain confidence and competence as decision-makers and to value decision-making as an essential skill for any nurse. They role modelled decision-making, they discussed the process sharing ideas with colleagues, they encouraged peer review, critical reflection, and journaling as helpful tools.

Across the decades you could see clearly how the participants cited those who had helped them and how they in turn moved on to help others who have since grown professionally. From this provision of support and guidance the nursing profession can gain some sense of the future possibilities in that if nurses believe in the value and importance of decision-making, this skill will not only improve in terms of knowing

‘how’, but some kind of ongoing guidance will be available for new generations of nurses.

In these four decades many decisions have been made that have advanced nursing in New Zealand as a discipline and as a profession. The ability to actively respond to any nursing situation and make progress is dependent on this first step – effective decision-making. The importance of decision-making is why this theme is the first square on the surface of the quilt, setting up for the remaining themes to sequentially deepen our understanding of the primacy of the nurse.

Chapter Five: An emerging understanding of autonomy and accountability

*“The health care system has always been ours even when our
authority and accountability have been weak or invisible.”*

(Dolan, 1978, p.344)

The second theme, ‘An emerging understanding of autonomy and accountability’ builds neatly on the focus of the previous chapter. While effective decision-making is an important skill to enable nurse and nursing to make progress, it is not enough on its own. It was clearly revealed in this study that to move forward positively, to ‘march’, individual nurses and the profession as a whole needed to be willing to be accountable for their nursing decisions and to feel free to act – free to make those decisions – to act in a context of professional autonomy. This chapter highlights the importance of autonomy and accountability in enabling nurses to confidently seize opportunities, to grow professionally and ensure the continuing primacy of the nurse in New Zealand.

As the source material was sifted through a series of contrasting processes, four content areas emerged. These are shown in Figure Five (redrawn on the next page). The first content area is about the real need for an exploration of terms (autonomy, accountability, authority, and responsibility) highlighting the complexity and diversity of the many interpretations revealed by the material. The second content area was the evolution of different understandings of these terms over time – an emerging clarity. The third content area explores the changing attitudes

and beliefs of individual nurses and the profession as a whole, and the fourth area reveals changing responses made by individuals and the profession.

Figure Five:

The first two content areas describe the struggle nationally and internationally to clearly articulate and understand the meaning and implications of autonomous accountable practice. The grappling for meaning by individuals and the profession as we sought to understand the impact of 'being accountable' and the conflicting interpretations of autonomous practice in a context of collegial practice and partnership. The third and fourth content areas again focus on the participants, as they revealed the individual understandings that emerged as they reflected,

reinterpreted their own experiences over time. How, as they gained experience, their understandings changed and new realisations emerged of the significance of the accountability and autonomy to ongoing professional growth. The participants' accounts clarified how important attitudes of self-belief and confidence are in supporting and enabling the nursing voice to be heard, and the importance of positive attitudes to change. The chapter concludes again with a synopsis of the attitudes beliefs and responses revealed by using the perspective of two individuals, two participant vignettes. Through this exploration we can gain a deeper understanding of personal attitudes beliefs and responses that Mia Carroll and Marie Burgess shared as they explored their maturing reflections about autonomy (Mia) and accountability (Marie). They shared their insights about the importance autonomy and accountability building on effective decision-making and continuing the journey outlining the attitudes beliefs and responses that support the ongoing primacy of the nurse.

The exploration of the terms was very important for me personally as the words autonomy, accountability, and responsibility seem to roll so easily off the tongue of many nursing colleagues – as if they are a cornerstone of the discipline of nursing. Yet is there really agreement about our collective understanding of the terms? Have we seriously searched for common meanings to enhance our understanding and interpretation? Analysis of the written and oral texts suggests that we have much still to do in the search for common understandings, acknowledging the diversity of our practice and the rich diversity of our perspectives.

This complexity and diversity was further explored by considering the struggles over this time period, wanting to be accountable, wanting to exercise practice autonomy, and the knowledge needed and gained to enable such practice to develop.

The experiences of the individual oral history participants were used to highlight some of the beliefs and attitudes that underpin the development of a sense of autonomy and accountability. An exploration of being open to change in relation to attitudes and beliefs and changes related to beliefs about nurses' independence, dependence and interdependence follow. The importance of confidence is emphasised and the place of the nurse' voice (or lack of voice) over time. Much of this information was not explicit in the written records, consequently the participant accounts make a valuable addition to our knowledge and understanding.

While the chapter like the first theme chapter is lengthy, I believe that the detailed exploration of the terms autonomy and accountability and the valuable insights of the participants enable us to be clearer about our professional responsibilities as individuals and as a collective. This is helpful in enabling me to build the links between the nursing context, the four theme chapters, and the primacy of the nurse.

Exploring the terms.

This **first** content area on the second square of the quilt explores the terms from the perspective of both the profession and individual nurses. These differing insights are used to reveal both the complexity of the concepts and the emerging maturation of an understanding of autonomy and accountability over time. The individual participant's struggle is outlined while seeking clarification and meaning of the concept of autonomy in a young profession where the individual nurse seldom really acts in isolation.

Woods (1985) stated that internationally the concept of 'professionalism' had appeared as a topic heading since the earliest international indices to nursing literature, in the 1950s. In New Zealand, the index to the *NZNJ* (the oldest NZ nursing publication) referred to 'professional standards' and 'professional status' in volume 3 (1910) and in the first ten years of

publication the *NZNJ* index lists published articles titled 'Nursing as a profession', 'The nurses larger sphere', 'The past and future of the profession'. Autonomy or accountability as concepts separated out from professionalism much later in the literature. Internationally the concepts of 'autonomy', 'power', 'politics', and 'political action' did not appear till the late 1960s. Autonomy did not occur as a separate concept in the *NZNJ* index in the 1970s, but the 1970 – 1979 index does include references to politics and policy making.

In the 1970s when nurses began to explore the concepts of autonomy and accountability applied to nursing, Maas, Specht, & Jacox (1975) wrote of the American Nurses Association (ANA) adopting a platform and programme aimed at establishing professional autonomy and accountability for nursing practice stating that nursing could no longer claim professional status without assuring all its attendant obligations.

When exploring ideas of professionalism and professionhood, international and New Zealand writers include the concepts of autonomy and accountability as central, key values, or the essence of professionalism (Fry, 1994; NZNA, 1993; Shetland, 1976; Styles, 1982; Wade, 1999; Watson, 1992; Wootton, 1989).

In a two-part article written in 1982, Lewis and Batey endeavoured to clarify the concepts of autonomy and accountability in nursing services. Their work is extensively quoted whenever nurses write about these two concepts in relation to nursing practice. They suggest that responsibility, authority and autonomy are preconditions for accountability, and that accountability is an exercise in futility and an experience in failure unless it is linked to nursing services autonomy.

The terms autonomy, responsibility and authority, and accountability are explored in more depth in the next section.

Autonomy.

Using many meanings and conditions discussed in the literature Lewis and Batey (1982a, p.15), define autonomy as “Freedom to make discretionary and binding decisions consistent with ones scope of practice and freedom to act on those decisions.” They suggest that the freedom to act is derived from both organisational structure and the individual professional – both being necessary for autonomy to be operational. The structure must allow the exercise of autonomy and the professional must perceive the freedom exists and be willing to exercise autonomy.

This freedom to act was illustrated by the participants who comment on situations when they perceived this freedom existed for them to practice autonomously (subject to their definition of autonomy). Situations where the participants perceived the structure allowed the exercise of autonomy included: Jocelyn Keith as a District nurse, Marie Burgess as a Public Health nurse, when they worked independently as nurses in the community; and Mia Carroll and Lee Mathias when they worked in speciality units such as in renal dialysis or intensive care, on a one to one ratio with their patients. They perceived the structure of the speciality unit as ‘allowing autonomy’ by having this responsibility for the majority of the decisions affecting one or two patients over an eight-hour period.

The importance of reference points – the structures, availability of people, mentors, role models, rules and regulations that provide guidance were common themes raised as the participants thought through and described their attitudes and beliefs about autonomy. This is beautifully exemplified in a quote from Yvonne Shadbolt where she described the significance of such reference points in guiding our activities, and how their absence provides opportunity for freedom to act if the individual is willing to exercise that freedom – learning along the way. I have taken a large

section of text to illustrate this point more clearly interspersing comment as appropriate.

I've certainly had periods of my professional life where I practised with a fair degree of autonomy and those are the ones we all find ourselves in – where we are away from many of the reference points...People you can refer to, or systems you work within and so on. I probably practised most autonomously in the very early days of the comprehensive programme at the Auckland Technical Institute – and I did that really by accident. There were a whole lot of rules and regulations that I should have been working to and knew nothing of – and there was a great deal of freedom - and I am talking about [freedom] in relation to the institution that I joined at that stage.

(Shadbolt, 2:7)

This experience was fairly typical of the learning curve required by both parties during the early years of the transfer of nursing education from the hospital schools of nursing into the tertiary education sector. The nurse educators were mainly from hospital schools where systems had been in place for years, where the 'rules' were explicit and guidelines from the Nursing Council quite specific. They came to an organisation within the tertiary education sector to start a new programme almost with a blank slate.

It is almost impossible for me to recall the absolute multitude of decisions that had to be made – minute by minute, hour by hour, day by day, when you start absolutely from scratch...The Tech wanted above all a list of equipment – well I could not even at that time imagine the shape of the curriculum...

There were so many decisions that had to be made for which there was no precedence for us, and we responded – we made the decisions on the basis of what we thought was best.

(Shadbolt, 2:7)

This ‘minute by minute’ decision-making illustrated clearly how the lack of reference points virtually forced autonomous activity. In these circumstances it was clearly important that the practitioner had both the willingness and the confidence to act in this context of relative freedom. The fewer people you had to consult or who were available to take over the decision-making, the more likely you were to make the decision yourself. It was interesting to note that this willingness to respond was indicative of many of the participants in this study.

One view of autonomy in relation to clinical practice is that autonomy is essential for the future development of nurses – autonomy in the sense that no other profession or administrative force controls clinical practice and the nurse is free to act in making judgements about patient care within the scope of her practice. Autonomy then has been linked to ideas of self-determination or self-direction. In this sense autonomy carries with it the implication that it is a permissive liberating phenomenon, and a positive phenomenon.

Everyone did not see autonomy in this sense. As discussed in the Mia Carroll vignette, New Zealand nurses have interpreted autonomy as meaning ‘total freedom to act’. Mander (1995, p.102), states categorically that “this clearly cannot apply if chaos is not to ensue”. Freedom to act as a nurse does not exist in a vacuum. There are many other people to consider when a nurse ‘acts’ not least being the patient, and their family as well as other health professionals. Mander (1995, p.102) in discussing the limitations on the ‘total freedom hypothesis’ cites Vaughan (1989) pleading for the idea of ‘attitudinal autonomy’ where the individual

practitioners perceive themselves as autonomous and accountable, have the self-confidence to take appropriate decisions and are prepared to accept the consequences.

Mia Carroll described the dangers of inexperienced practitioners holding on to the freedom offered by the idea of autonomy without really understanding the necessary associated concepts of responsibility and authority. Mia spoke of their lack of openness to professional dialogue, to peer review, to expanding knowledge and developing both 'situational authority' and the 'authority of expert knowledge'. The absence of mentors and peer review can contribute to this misunderstanding of 'attitudinal autonomy'. I believe we still have some issues to sort out here in relation to some R.Ns ideas of autonomy. Tensions exist, and if we persist in pursuing the idea of 'nurse autonomy' we may find that when considered alongside 'choice,' and 'partnership' we may be limiting our options, and developing 'autonomy in isolation'. We may also not be acting on the best interests of the patient.

The need for the structure to allow the exercise of autonomy and for the professional to both perceive that the freedom exists and to be willing to exercise that freedom is as important today in 1999 as it was in 1982 when Lewis and Batey first wrote about the concept of autonomy.

While individuals were making progress in exercising autonomy, writers and commentators both nationally and internationally have expressed concern over the decades at the contrasting lack of autonomy exercised by the profession as a whole (Bowman, 1995; Dell, 1980; Dixon, 1990; Instone & Stevenson, 1987; Perry, 1993).

The variety of perceptions that can exist even in one setting is illustrated in a study by Bowman (1995) reporting on a major piece of research carried out in the United Kingdom. Bowman suggested nurses believe they have responsibility for care but are not empowered or free to make

decisions that ensured that these responsibilities were properly met. In a study on impediments on exercising authority and autonomy, Bowman reported that very few nurse respondents felt they were “extremely free” to make decisions. In this study ‘Ward Sisters’ commented on Doctors having prescriptive care, and believed that nurse managers inhibited the ward sisters’ freedom to make decisions. The nurse managers on the other hand believed that nurses were free to manage their wards but that the ward sisters thought they were constrained tremendously and used this perception as an excuse for inaction.

In response to the question of whether the professional nurse has authority and autonomy there were many contradictory views. Managers believed nurses had the requisite authority and autonomy. Nurses said they didn’t, giving as examples their lack of control over staffing levels and the consequential insufficient cover to meet patients needs. Doctors said the nurses were frightened of their superiors and do not have authority and autonomy. Professional bodies said nurses have authority but fail to use it because of their lack of assertiveness, and feeling of subordination (Bowman, 1995, p.75-76).

This perception of the professional bodies that nurses fail to act autonomously because of their lack of assertiveness and feelings of subordination, is supported by a 1997 American study, described in an article on ‘autonomy’, where the participants were perceived to act assertively. A group of nurses in a small rural psychiatric hospital using participatory research as a tool to explore issues of autonomy, found that they were able to successfully challenge the institutional norms and ideas that limited nurses’ autonomy (Breda, Anderson, Hansen, Hayes, Pilon & Lyon, 1997).

As an additional comment I have often thought that in considering autonomy of the profession in the New Zealand context, we have not

taken into account the relative 'youth' of the nursing profession in New Zealand in relation to hospital based clinical workforce compared with some other parts of the world, particularly North America. In New Zealand the development of an R.N based workforce providing the bulk of clinical nursing care in the hospital setting is very recent (since 1985). Maturation of a sense of autonomy both in relation to decision-making and practice autonomy does not develop overnight. We need to consider interdependence with other members of the health care team, to separate aggregate professional autonomy, from personal autonomy and work autonomy as described by Lach (1992).

Any exploration of autonomy is not complete without reference to the associated concepts of responsibility and authority.

Responsibility and Authority.

When Lewis and Batey (1982a) discussed accountability they were at pains to separate out the difference between responsibility and accountability – often seen as synonymous in the literature. They defined responsibility as “a charge for which one is responsible and which can be derived from external or internal sources”, and accountability as “the fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results income and expenditure for which one has authority” (Lewis & Batey 1982a, p.10) with the focus being on disclosure.

Examples of responsibility derived from external sources include legislation and regulation. Styles (1986) acting as an international consultant on nursing regulation, reported that in examining nurse practice laws in over 100 countries for this ICN project, she found that legislation or other government standards often constricted nursing practice. This is done through stipulations about physician supervision, narrow and prescriptive definitions of the scope of practice or lists of procedures that

nurses must not perform despite education and experience or public need. This is not the case in New Zealand where there is no statement in law that prescribes or puts boundaries around the practice of the R.N. Some nurses perceive this as a disadvantage, providing too little guidance to the practice of the nurse – they want some of the parameters of the scope of practice spelt out in legislation. On the other hand other nurses see the lack of specificity as an advantage – there are no limits, no boundaries to the changing scope of clinical practice.

This argument is well illustrated by the present ongoing debate on whether the nurse should have the right to ‘prescribe’ medication. Midwives obtained prescribing rights along with an amendment to the Nurses Act in 1990. There were no limits to this ‘right’ as long as medication prescribed was within the ‘scope of practice of the midwife’ as defined by the midwifery profession. With the debate on the prescribing rights of the R.N, the idea of prescribing over the broad and diverse field of nursing and allowing nurses to define their ‘scope of practice’ is seen as the way to go forward by some nurses. Others see issues of safety and lack of knowledge precluding such a course of action. In the wider context such a broad approach is not acceptable to the medical profession or to some of the health service providers and is therefore likely to be perceived as politically unacceptable. A compromise is likely to be reached with current suggestions of pilot programmes associated with prescribing within the scope of practice in caring for the older adult, and children. The tension is played out between achieving a balance that both enables freedom to act and also protects the public.

Internal sources of responsibility are associated with each individual nurse’s job description and the responsibilities expected within her scope of practice. Seeking to achieve a balance between individual freedom to act responsibly based on professional judgement, and the imposition of external controls is a common tension. Should the profession be regulated

and controlled in the sense that protocols and boundaries are predetermined and established that narrow, tighten down, or minimise freedom to move in diverse changing circumstances? Or should there be a focus on constructive self-regulation or at least broad enabling regulation that encourages the sense of individual responsibility? The individual can accept responsibility for their practice – ‘I know what I can do to act responsibly within the scope of my practice’ or hide behind perceived controls – ‘They won’t let me do that’. The worst case is where the individual has an attitude of learned helplessness, and perceives that external controls minimise whatever freedom there might otherwise be. Reading the *NZNJ* in the 1990s is illustrative of this perception (Gunn, 1997; O’Connor, 1999; Stodart, 1993/4; Warr, 1995; White, 1997).

Tensions exist in examining the concept of authority too. Too many rules and regulations, which deny individual freedom to act, inhibit development of a sense of responsibility, and flow on to narrow an individual’s scope of practice. Tensions of unresolved perceptions of loss of positional power and associated authority influence our response to individual responsibility and how we cope with positional authority. The new ethic of decentralisation and individual responsibility has been and still is a challenge many are grappling with.

In exploring the concept of ‘authority’, Duff (1995), described the sources of authority as “authority of expert knowledge, situational authority, and positional authority” - the authority of expert knowledge existing when the nurse is granted the “rightful power to assume certain responsibilities through a license or place on a register” (Duff, 1995, p.52).

An example of expert knowledge would be where a mental health nurse, who is on the psychiatric or comprehensive nurse register, may be granted the right to be a ‘Duly Authorised Officer’ (appointed among other things to give practical help in dealing with people who have mental disorders).

This responsibility would not be assigned to an RGON or a midwife. Situational authority is linked to the rightful power to fulfil what needs to be done according to the situation e.g. in an emergency, the kind of protocols set down in cardiac arrest situations. Positional authority is tied to a formal position and/or individual. Stevens (1976) an American nurse, who writes extensively on nursing administration and management, calls this administrative authority.

Sally Shaw beautifully illustrates the tension associated with the perceived loss of positional power in describing her experience with nurse leaders both in New Zealand and internationally. She used the term 'positional power' when commenting on her appointment as Director of Nursing in the Department of Health in the 1980s

The department was going to bring about changes...I went into a position that was no longer 'secure' in the traditional sense of the Director of Nursing. Those who had held the position before me had a degree of 'positional power'...it was very clear that that was going to change.

(Shaw, 2:14)

Sally also spoke of her experience with colleagues in the 'positional power' of Chief nurse. She described the attitude of one particular person, and then the group as a whole.

Individual 'B' had been no slug when it came to making decisions, and she had fought for things within a structure, a health service structure that gave her a certain degree of power. [She fought] when she could use that power to lobby and influence people, both in nursing and board members and others. But when she felt that she would be losing that positional power then she could not find another way to influence things. It wasn't her style - she couldn't do it.

This response is not an issue of freedom – the choice to use power and influence as this person had done in the 1960s and 1970s was still there. The response was linked to an attitude to change. Change can be threatening to some, and finding new ways of dealing with changing times can sometimes be an issue of personal confidence, and affect the ability to take risks. Positional power can also be perceived as providing ‘authority to act’. The withdrawal of positional power is then perceived as withdrawing that authority – the unresolved tension of loss of positional power and how we then cope with authority.

While individual nurses may have resolved this tension as illustrated by some of the participants in this study, the profession as a whole still appears to be grappling with this issue world-wide. Sally described situations internationally, in her work in several continents on the ‘Leadership for change’ project as a nurse consultant for ICN. She particularly commented on the fact that some nurses in ‘positional power’ never actually used the opportunities the position provided.

I've seen that in nursing when people in many countries have tried to hold on to positional power when health services are restructuring. In some countries they've fought for the nursing component to stay the same...to have the comfort of having positional power. The reality is that some of those people [who had positional power] didn't use it...Some of them have never been able to find ways of exerting 'influence' rather than 'power' in a different kind of way. Some have been very adept at that – positional power versus new ways of having influence. A lot of the upheavals and restructuring and everything else we have seen has really shown up for people.

Everything that relates to this – decision-making, autonomy, and accountability, within that context, changes because the ground's changed.

(Shaw, 2:7-8)

When threatened by the possible loss of a title or position of authority that nurses perceived gave them 'power', their role may be reduced to one that is passive and non influential as a result of their perceived lack of authority to act. One needs to question such attitudes especially in times of health sector restructuring moving from hierarchical structures to more horizontal structures.

As Sally states in the above quote, we need to develop a variety of ways to influence decisions. We need to claim the authority to act when nursing decisions are required or would add to the effectiveness of health policy and practice.

Miller (1980, p.45), a New Zealand nurse academic writing about nurses and power, suggests that while nurses have considerable power, "generally we do not recognise this power or else we avoid it". Perry (1993, p.47) suggests that "nurses lack of authority is not the fault of passive individuals, but a system of health care which values caring as non-scientific work".

I am not so sure that we can put all the blame on the 'system'. There have been too many examples of where the individual nurse has taken the authority and the freedom to act and gone on to make a real difference whatever kind of 'system' is in place.

Another perspective on the concept of autonomy was provided by Dachelet and Sullivan (1979) writing about autonomy as a central concept in professional practice. They describe 'job content' autonomy (determining the methods and procedures to deal with a problem) and 'job

context' autonomy (freedom to name and define boundaries of the problem, role relationships with other providers).

I believe this is a useful perspective to examine. 'Job context' autonomy seems to me to be the issue for nurses in the 1990s. We appear to be clear that within the context of nursing and the scope of our practice, the nurse is the authority on matters 'nursing' – 'job content' autonomy. Administrators and other health professionals as well as nurses readily acknowledge this. The issue however is how we maintain our 'job context' autonomy as a profession in the wider context, while at the same time dealing with those multiple accountabilities in today's complex health environment, the concepts of collaborative practice, and the unclear boundaries and 'turf' battles between the health professions.

How do we provide support for or precept new graduates and inexperienced practitioners? How do we encourage nurses to be open to professional dialogue, critical appraisal, peer review? What will enable us to shift the individual practitioners focus from the activities of the nurse, to the outcomes for the patient, so we can best fulfil our charge to the patient and their family?

We are moving into a new era of professional freedom and if we develop and use concepts like autonomy, we must be very clear that as a profession we are coming from a similar understanding. Autonomy in the sense of freedom to act in relation to both job content and job context, in a context of partnership and collaboration will surely provide a setting where the best interests of the patient will prevail.

Misunderstandings of the concepts of autonomy, authority and responsibility can create issues of critical importance to the future development of nursing. The structures we work within need to allow the exercise of autonomy, authority and responsibility, rather than constrict freedoms. The profession needs to both perceive that such freedoms exist

and be willing to exercise that freedom. The individual needs to acknowledge that tensions will exist between the profession and individual practitioners, and that the state of maturation and development of both parties may cause such tensions. The individual should be encouraged to acknowledge the role of experience (expert knowledge) and confidence, in the maturation of a sense of autonomy, responsibility and authority, and the significance of reference points in guiding our activities.

As structures and roles change we must find new ways of dealing with changing times, so we can meet the preconditions for accountability – by developing a sense of autonomy, acting with authority and accepting responsibility.

Accountability.

In moving from examination of the concepts of autonomy to authority and responsibility, and now the concept of accountability, I believe we face another complex matter. As previously stated, Lewis and Batey suggest that responsibility, authority and autonomy are preconditions for accountability, and in turn accountability needs to be linked to nursing service autonomy. Wade (1999) claims individuals who exhibit professional nurse autonomy have the courage to make choices (decisions) and assume responsibility for their actions – to be accountable.

In order to understand the links between autonomy, responsibility, authority and accountability, not only do we need to address a definition of accountability and explore who can be accountable, why we are accountable, and for what are we accountable, but we also need to consider to whom is the nurse accountable? Nurses internationally and in New Zealand write about our multiple accountabilities – to the patient; doctor; employer; profession; the professional body; society; and ourselves (Donabedian, 1976; Fry, 1994; NZNO, 1993; Shetland, 1976;

Styles, 1985b; Watson, 1995) and collective accountabilities (Maas, 1973).

In 1979 Olive Anstey, an Australian nurse elected President of ICN 1977-1981, reported on the word 'Accountability' as the watchword for the previous ICN President Dorothy Cornelius during her four year term of office. Anstey quoted Cornelius as follows

The watchword accountability acknowledges that ICN and its constituents welcome scrutiny of its goal and activities. It also implies that ICN recognises its responsibilities to nurses and to the consumers of nursing practice throughout the world...The concept of accountability denies isolationism...Thus accountability can form a caring circle under which nursing can function with its validated unique body of knowledge. I believe that the radius of such a 'circle of accountability' would be unlimited in it's potential for growth.

(Anstey, 1979, p.28)

McCoppin and Gardiner (1994, p.62) Australian academics, suggest that Anstey "recognised that accountability to the patient could bring the nurse in conflict with those further up the hierarchy", and emphasised the collective responsibility of the nurse.

Even where there is some agreement regarding a definition of accountability, the **extent** of accountability that the nurse currently operates under appears to be in question. This is well illustrated in the variety of views presented in the text '*Accountability in Nursing Practice*', edited by Watson (1995). In the introduction to his book he states clearly that

this book sets out to illustrate the nature of accountability as it is operated in a variety of specialties and illustrates this with the relevant philosophical, legal and ethical arguments. In addition it sets out to inform the ongoing debate in and around the profession so that the matter of accountability can, perhaps, be seen more clearly, with its attendant difficulties, by a greater number of people.

(Watson, 1995, p.5)

Rebecca Bergman (1981) an international leader in professional development and nursing ethics suggested that for a person to be held accountable, all of the following are required: Ability - the relevant knowledge, skills and values to make decisions and act; Responsibility - given to the person to enable them to carry out the action; Authority - the formal backing to carry the action through, i.e. the power to make sure that it happens.

Lewis and Batey (1982b, p.10) in separating out responsibility from accountability, defined accountability as “the fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedures, relationships, results income and expenditure for which one has authority” with the focus being on disclosure.

Professional practice for which the nurse can be called to account is perceived as central to the integrity of the role of the professional nurse – why we are called to account. The United Kingdom Central Council (UKCC) for Nursing Midwifery and Health Visiting, suggested that public trust and confidence in the nursing profession may depend on its practitioners being seen as accountable and responsible. Increased responsibility it would seem brings increased accountability. In 1989, Colin Ralph, in his position as Registrar and Chief executive to the UKCC, suggested a working definition of professional accountability as

that obligation on the practitioner that binds (the nurse) to a code of conduct, based upon the expectations of society, that she will use her discretion and skill to safeguard her patients, and act in every way to uphold professional standards.

(Royal College of Nursing of the UK, 1990, p.4).

In the NZNO document *Standards for Nursing Practice* (1993, p.8) Standard One is 'Nurses are accountable for their practice', with accountability defined as "The acceptance of rights and responsibilities of conduct and behaviour. It is the acceptance of responsibility to self, profession, client, employer and the community as a whole."

The magnitude of the task of the acceptance of multiple accountabilities was described by Yvonne Shadbolt when she discussed how she would try and map out to her nursing students just where and to whom she felt accountable. The tensions revealed in this example from the 1970s outlining the demands of multiple accountabilities are still relevant today. Yvonne described these multiple accountabilities in relation to the beginning of the comprehensive programme at AIT. While accepting accountability to her employer, the real challenge was accountability to the profession who had worked so hard for the transfer of nursing education out of the hospital sector and were watching developments of the programme critically.

*I'm certainly accountable to the organisation where I worked, to the profession, and certainly when we started the comprehensive course we were very **very** conscious of the fact that this was, if you like, a pilot for a new approach to nursing education. Ardently desired by that profession and its organisation, and the importance of it succeeding - with everyone watching.*

(Shadbolt, 2:6-7)

The significance of the programme to the students was also important as they were to be a new 'type' of nurse, as well as paying a significant amount of up front costs for their education in contrast to the hospital based students who received a salary.

I felt accountable to the students who were investing time and forgone earnings and hopes and aspirations in the programme. I certainly felt accountable to the people that worked with and for me, and so it went on. To the patients and clients that we touched upon as part of the learning, and certainly that our grads would serve in the future. Then of course the social contract with the public of New Zealand who was paying for it all and who was only doing this so that in the final analysis they could be sure of having as effective nursing workforce available...So I mean when you really started to map out the near and far, the personal and more distant, the integral to me as a professional, to me as a person, to me as a teacher etc, your range of accountabilities are large.

(Shadbolt, 2:6-7)

Yvonne encapsulated neatly in the last paragraph above the range, complexity, individual, and collective components of multiple accountabilities.

Sally Shaw highlighted the many different perspectives that need to be considered when accepting responsibility and accountability for your actions in a management role, again linking these concepts to decision-making. She commented on the variety of factors that need to be weighed up, including conflicting points of view, and the factors to be prioritised before decisions are made, thus illustrating the complexities in the health sector (and probably in many other management situations).

You have it all the time in management where you have to make decisions, where you have to weigh up a number of things. What is right for the individual, what is right for another individual, what is right for the organisation, and sometimes what is right for the community. I mean there are always conflicting things at the management level that come in decision-making...It gets very complex in health and I don't think that decision-making is easy.

(Shaw, 2:6)

Sometimes we forget the personal toll on those in senior positions where accepting responsibility and accountability for decisions that will not please everyone have to be made in order to move forward.

Sometimes there is a personal cost in it which other people don't appreciate because they (and of course it's understandable) that people will view situations from the perspective where their responsibilities lie and that may bring in a lot of anger and frustration and fears and emotions and everything else as well.

(Shaw, 2:6)

It is not only individuals and the professions themselves that are concerned about accountability. The concerns of society about the level of accountability of the professions have been with us for several decades, with writers commenting about perceived self-interest as the motivator for autonomy and the recurrent theme of lack of accountability leading to public discontent (Daniels, 1989; Goode, 1969; Hughes, 1965; Merton, 1960; Roth, 1974; Schein, 1972).

The issue of legal accountability.

An increasingly relevant issue for the nurse in many countries including New Zealand is legal accountability and liability. Articles and texts related to the nurse and the law are increasingly common internationally

(Affara & Styles, 1992; Creighton, 1986; Faulder, 1985; Staunton & Whyburn, 1989; Wakeford, 1973), and in New Zealand particularly over the last two decades (Burgess, 1993; Bush, 1997; Hayes, 1982). Under current New Zealand legislation, the penalties for failure to be accountable within the scope of practice of a nurse can be severe. Such penalties include the removal of the nurse's name from the register or roll, which means they can no longer practice as a nurse, suspension from the register or roll for a period, permission to practice only under specified conditions, a fine and costs of the disciplinary hearing, or censure.

While we have been aware of the litigious nature of the health service in the USA for many years this has not been the case in New Zealand until the 1990s. Since the mid 1990s, the increased legal accountabilities that exist with the Health Commissioner and with ACC have complicated the role of the statutory regulatory body, the Nursing Council. Reported long delays between an incident and the hearing associated with that incident cause problems both for the individual nurse, and for the profession attempting to protect the health and safety of the public.

Bush, NZNO legal advisor, suggests that New Zealand nurses have been potentially accountable but in reality have had relatively little accountability because of our "less litigious society [and a] perception that nurses were not professionals, and were not autonomous, and therefore doctors and/or hospitals were responsible, not nurses directly" (Bush, 1997, p.1).

In a North American context, Crowe (1991) cites Flaherty, speaking as an expert nurse ethicist witness, in a nursing appeal relating to professional misconduct for failing to check an unusual drug. "A Registered Nurse can never say policy made me do it, or the head nurse made me do it, because a nurse is accountable before society, before herself and before God" (Crowe, 1991, p.118).

Marie Burgess in the second edition of her New Zealand book *A guide to the law for nurses and midwives*, emphasises that

Every health professional is responsible, accountable and therefore legally liable for their own actions...It is sometimes believed that senior colleagues or medical staff will cover or accept responsibility for some particular task a nurse or midwife is asked to do. If something goes wrong, then those senior to the practitioner may also be held accountable, but it will not remove the responsibility of the practitioner for their own actions in the situation.

(Burgess, 1996, p.127)

The professional obligations of the nurse while not written in legislation in New Zealand “implies services of a particular standard...Society expects of its nurses and midwives a standard of conduct, both personal and professional, which is higher than that of the ordinary citizen” (Burgess, 1996, p.60).

Professional accountability is still an issue in the late 1990s. Internationally the politicians and policy makers have spoken of their perceived notion of ‘professional capture’ over the past two decades, where they perceived that the professions primary concern was often one of self interest rather than the good of the patient or society as a whole. The media and the public in New Zealand were also not convinced of the intentions of health professionals. Daniels (1989) a senior lecturer in social work at Canterbury University, suggested that in the 1980s there was a well established pattern in our society of questioning, challenging and critiquing of health professionals, representing a growing concern about the power health professionals had and the way those in authority used that power. Individual incidents reported in/on the daily news and complaints of professional misconduct made by the public to appropriate

authorities would leave me to think we still have a long way to go to really earn the trust of the public and to demonstrate accountability for our actions. The New Zealand Health Commissioner, Robyn Stent was quoted in a 1998 report of an NZNO Nursing and Midwifery Advisory Committee meeting as saying, “Nurses and midwives are valued professionals. Like all professionals nurses and midwives might feel besieged from time to time by the amount of legislation and/or the negative attitudes of society in general” (Stent, 1998, p. 22).

Nurses, however, top the respect poll in a New Zealand national survey seeking the view of the public regarding which profession they most respect. This has occurred every year since nurses were added to the poll in 1994, and were supported in 1999 when a local media commentator suggested that the public would not stand for criticism of nurses. This was despite nurses’ strikes, and protests over this time. The public respect for nurses in New Zealand needs to be carefully nurtured, however, as in some countries, the media and politicians have at times been merciless in their criticism of nurses over strikes and protests (e.g. Australia, United Kingdom).

While the 1960s–1970s ensured that nurses learned the kinds of attitudes and behaviours that perpetuate tradition and ritual, in the 1990s we are seeing the growth and maturation of the profession in New Zealand especially in relation to individual nurses. Individuals **are** claiming professional authority and accountability both within and without health care institutions, and they **are** acknowledging the freedom they need to act. The question is how to move the profession as a whole, while it still appears to be grappling with what autonomy means and how to exercise it. The critical mass is not realised easily despite the mandate of respect from society. I believe that one of the keys to this development is the change in focus to put the patient at the centre of all that we do. This then could grant to individual nurses working in partnership at the nurse patient

level, the decision-making authority in matters that are clearly nursing. The rapid throughput of patients in the hospital setting needs authority and accountability at this level. Current work on health care outcomes, evidence based practise, and measuring the contribution nurses make to the health of New Zealanders could enhance this ability (French, 1999; Hughes, 1999; ICN, 1999; Ministry of Health, 1996, 1998; Peach, 1999).

NZNRNs in the hospital setting today could meet the first two requirements deemed necessary to be held accountable, previously proposed by Bergman, that of ability and responsibility. It is the third requirement, obtaining, or claiming the authority to carry the action through – to make it happen, that seems to be difficult for some. A significant factor influencing the emerging understanding of accountability is I believe the responsibility of the individual nurse to be clear that in decision-making related to the nursing care of patients and their families, the **nurse** is the expert, and the **nurse** should carry the action through. It is also important for us as a profession to acknowledge that we are increasingly expected to be visibly accountable.

Used effectively, accountability is an ideal means of demonstrating the unique contribution made by nurses. In order to achieve such recognition nurses themselves must be convinced of their own value to patient care and must be able to clearly identify the boundaries of nursing.

(Chalmers, 1995, p.48)

With clearly defined standards for nursing practice, ethical codes, and codes of conduct spelt out for the nurse, alongside a Patients Code of Rights and Responsibilities, that accountability should be visible indeed.

This section has explored the concepts of autonomy, responsibility and authority, and accountability and the tensions that exist for both for the individual nurse and for the profession generally. The developments in

New Zealand have been slightly behind some other areas of the world but they mirror such developments in the establishment of standards, codes of practice, and regulation. It is clear that the ability to make decisions is critical in moving on to the exercising of autonomy and accountability and in turn the opportunity for 'practice autonomy', freedom to act, enhances decision-making.

This beginning exploration of terms has been planned to form the basis on which to build the remainder of the chapter – the study of some of the contextual influences and then the changes in the practice and beliefs of the R.N that impacted on the development of a sense of autonomy (subsuming responsibility and authority for much of the rest of the chapter) and accountability. The second content area on the second square on the surface of the quilt is about the emerging clarity and evolution of different understandings of autonomy and accountability influenced by the context and the experiences and maturation of the participants.

The contextual influences on understanding

This section addresses contextual influences on the development of a sense of autonomy and accountability in relation to the profession generally, and should be read in conjunction with chapter three, which provided a discussion of the nursing context. There are **three factors** expanded on in this section and threaded together from different sources. The **first** is the impact of the 1990s health service 'reforms' on the issue of accountability in its widest sense. The **second** is the significance of teamwork in the context of accountability primarily as expressed by the participants in the study as they developed their own sense of autonomy and accountability. The **third** factor highlights the question of how we balance external 'controls' affecting the profession and 'controls' within the profession (self-regulation) including ethical codes, competence,

standards of practice, and measures of quality, influencing the development of a sense of autonomy and accountability.

Impact of health service 'reforms'.

The issue of accountability was certainly not unique to nursing in the health sector. Watson (1995) suggested that the advent of health service reforms in the United Kingdom raised the issue of accountability in the health service generally. In New Zealand this was certainly the case with the politicians, the media, the funders, the providers, the health professionals and the public all questioning accountability. Who is accountable? Who should be accountable? Where does the 'buck' stop? Knowles (1994) also from the UK, considers that the health reforms have demanded an explicitness and transparency in health-care purchasing decisions, and suggested that inevitably this will put pressure on nurses. This pressure on nurses can take many forms and in New Zealand has been widely reported in the *NZNJ*, by the Coalition for Public Health (a political lobby group), and in the general media. Nurses have expressed their concerns at the perceived focus on cost – the 'bottom line' to the detriment of standards of care, and frustration at an inability to provide the patient with the care the nurse perceives the patient is both entitled to and needs.

The lack of continuity within the New Zealand Parliament and the Health Ministry has, I believe, had a major negative influence on issues the health professions have considered significant. New Zealand has had eight (8) Ministers of Health between 1987 and 1999. Bassett, Caygill, Clark, Upton, Birch, Shipley, English, Creech (and many more Associate Ministers). This occurred during a period of major change, restructuring, and change of direction in the health sector. The Department of Health also changed to a Ministry, and restructured several times. Each change

meant new relationships needed to be established and new understandings reached within and between the leaders and shakers in the health sector.

An experienced NZRN, quoted in the March 1999 issue of the *NZNJ*, in a story about her leaving nursing after many years in practice, said that she had never considered nursing a 'job', but a profession she'd enjoyed and been proud of. However the political upheaval in health over the past few years combined with major restructuring at the hospital have worn away her commitment to nursing.

Basically the changing health system has disillusioned me. We've had too many changes at [the base hospital] in too short a time and we just couldn't cope with any more. I am told that the hospital deficit is reducing, but no one seems concerned what the cost to the staff has been. There are no incentives left for wanting to do a better job.

(McGuinness, 1999, p. 9)

Who is accountable to and for the staff at this hospital? Where is the opportunity for the nurse to accept responsibility and authority for the standard of care she is able to provide? Can she exercise real 'practice autonomy'? While the government of the day has endeavoured to distance itself from the issue of accountability in the health sector, the general impression in the late 1990s is of an overall lack of accountability across the public service linked to individual rather than collective values (Maharey, 1999; Upton, 1999). The question of who is/should be accountable raises issues for both the individual and the 'team' in the health sector.

The context of teamwork.

Grappling with the tensions of the question of autonomy and accountability in relation to teamwork and working with others has been

complex. There was not a lot to be found in the literature, but many of the participants had been required to address this concern in their day to day work. I have used several extracts from their accounts to illustrate the tensions, and pulled them together at the end of the section.

Yvonne Shadbolt linked decision-making to accountability, emphasising the importance of accountability for that final decision when in a leadership role, even though the very nature of much decision making is not autonomous in the sense that you have to consult with many other people.

If you make decisions, many of these are not autonomous in the sense that you have to consult with many other people. Get their opinion, get the input – so you wouldn't necessarily say that is autonomous. And yet, in another sense the final decision may be yours and that is [making the decision] autonomy but certainly it's something you will say you will be accountable for.

(Shadbolt, 2:5)

Jocelyn Keith in describing working in the community emphasised the value of what the self-confident nurse can bring to the health team and the importance of valuing nursing knowledge.

You work in teams much more and you will share care ... You realise what it is that the nurse is bringing to the feast and how you can operate as a team member...That's [an]enormously valuable realisation because you'll suddenly be valued for your own knowledge and the contribution you can make.

(Keith, 2:4)

Mia Carroll explored the development and maturation of the sense of autonomy for her which in more recent times had developed into a strong focus on collaboration – suggesting that autonomy (in the sense of

capacity/freedom to choose) is strengthened when we act in collaboration with others rather than relying solely on our own resources.

I think that autonomy and capacity to choose is strengthened by collaboration. I've stopped promoting nurses as autonomous practitioners. I think what we now discuss with nursing staff is that there is a level of capacity to choose differently but it is always in collaboration with others – partners of clients, partners of families, partners of every other discipline that's around.

(Carroll, 2:5)

Marie Burgess in her role as a consultant offering seminars for a multidisciplinary audience, explored the value of multidisciplinary discussions as reference points, and really getting to know what other professions we work with think, rather than assuming that we know already, which is not necessarily the case.

*What I've learned is the importance of actually mixing health professionals. We are often doing things, and I guess in my professional life it has been mainly doing things **within** the profession, and although we work together with other health professionals we've not always participated in education together. That's been one of the things I've been conscious of and keen to foster in the work that I've been doing at the moment - to encourage health professionals to meet together at the seminars and actually discuss some of the legal and ethical [issues]...We often think we know how doctors/physios will think – not necessarily the case at all.*

(Burgess, 2:15)

This inward focus 'doing things within the profession', was a significant comment as an international survey conducted by ICN in 1998 suggested that many national nurses associations tended to have a narrow focus, on

the nurse and nursing – the profession, with little consideration of global trends, concerns of other members of the health team, or the concerns of society at large.

Each of the participant's comments above, link in some way to a professional outcome related to autonomy and accountability within the context of working with others. The ability to work as part of a team and clearly see the specific contribution the nurse makes is linked with growth of the profession as a whole – as we acknowledge the role and skills the nurse brings to a situation. The capacity/freedom to choose in collaboration with others and understanding how an individual in the team does not give up their autonomy but is strengthened by accepting responsibility to work with and alongside others.

Perhaps when health professionals acknowledge that the patient is the real focus, each member of the health team will be able to provide their contribution in a way that acknowledges the role and views of others in the team. This may stop us as nurses from being inwardly focused and 'precious', helping us to clarify what constitutes the nurses' contribution. In nursing we have clearly not worked through the issues of how we should respond in relation to autonomy and accountability as these concepts impact on the individual, or the profession in the context of teamwork.

The balance between external and professional 'control'.

Styles (1982, p.22) in her text exploring ideas related to professionalism and professionhood, comments that "the literature is amazingly repetitious with attempts to define professions and professionalism by their distinguishing characteristics". She suggested that autonomy is viewed by many as the key value of the professions and that bound up with autonomy is the obligation of self-regulation or professional control (Styles, 1982, p.27). In New Zealand as the post registration education of

nurses increased in the 1970s and 1980s, nurses began to study in more detail the discipline of nursing including the characteristics of a profession and professional control. Professional control including self-regulation and discipline, often guided by regulatory legislation, expected competencies, standards of conduct, and ethical codes.

Autonomy is granted to a profession with the understanding that it will itself, without outside interference, regulate or control the performance of its members. Since the 1970s the profession in New Zealand has mainly adhered to the suggestion of Freidson (1972) that just as autonomy is the test of professional status, so self-regulation is the test of professional autonomy.

The many changes in health, education, and social policy during the 1980s and early 1990s have not been acknowledged in the amendments to the legislation. The nursing profession in 1999 finds current legislation (Nurses Act 1977) in urgent need of review to reflect current practice, and to acknowledge the growing autonomy and legal accountability of the profession.

Despite the frustration of outdated legislation, the profession has developed voluntary 'codes of conduct' or 'codes of practice' as a self-disciplining guide to professional behaviour. This is in common with many other professional groups in the health sector in New Zealand, and with nursing groups internationally (Fry, 1994). Such codes do not have the power to require compliance but are established through ongoing consultation within the profession concerned. The Nursing Council developed a voluntary Code of Conduct for nurses and midwives in 1995, which is issued to every nurse holding a current practising certificate. Burgess (1996, p.37) described the intention of the code and its 'basic' principles as follows

The code is intended to provide a guide to the public on assessing minimum standards, a guide to nurses and midwives on monitoring professional conduct, and a guide to the Council itself in applying its judgement on professional conduct at disciplinary hearings. There are four 'basic' principles which provide the framework of this code of conduct: that nurses and midwives comply with legislated requirements; act ethically and maintain standards of practice; respect the rights of patients/clients; and justify public trust and confidence.

(Burgess, 1996, p. 37)

Ethical codes are another way of guiding the profession to self-regulate itself. When NZNO revised its Code of Ethics in 1995, underlying values were included: autonomy, beneficence, non-maleficence, justice, confidentiality, veracity, fidelity, guardianship of the environment and its resources, and being professional.

As well as identifying ethical principles and guidelines we need to have both clear definitions of competency to practice, and clear statements of the required standards of practice to be met if we are to be clear about practice accountability. The profession as a whole needs to provide the necessary guidance and direction.

Competence to practice has been increasingly seen as important as questions are raised relating to meeting standards of nursing practice and providing the required quality of care. The current nurse's Annual Practising Certificate (APC) which was first introduced in 1939, is issued by the Nursing Council on receipt of an annual fee, and is in reality only evidence that the nurse in question has paid the required fee, is still on the Register or Roll, and has not fallen into disrepute. Both NZNO and the Nursing Council have worked hard over the years to develop measures

and processes acceptable to the profession that could provide a reliable measure of competence to practice as a nurse.

An important issue identified by the participants was how to provide objective measures of competence for members of the nursing profession when their scope of practice is so broad, and varied? This question was especially important for nurses who saw themselves in positions where their practice was not primarily at the bedside, but underpins the very nature of their work. It goes straight to the issue of what is meant by 'scope of practice'. The Nursing Council guidelines (1999) included the following provocative statement in light of the controversial interpretation of the term nursing practice mentioned in the introductory chapter.

It [scope of practice] focuses on nursing practice. Those engaged in education, research and/or administration/management in nursing contexts may influence nursing practice but are not directly practising nursing.

(Nursing Council, 1999, p.7)

How these Nursing Council guidelines are used will be another example of the tension between individual responsibility for establishing competence to practice while operating within the professional jurisdiction of practice, and external controls predetermining competence. Will the guidelines be interpreted as broad and enabling, or as narrow and confining?

Lee Mathias provided a good example of the difficulties in creating a process of measuring competence that suits all situations. She stressed the importance to her of flexibility in the development of any recognition of current competencies to practice, especially reference to the kind of educational courses or programmes that are being proposed as part of the criteria for measuring competence.

I provide a huge inservice for myself – this year this includes a five days Institute of Directors course. This is just as important for me [as clinical inservice] in the role I have as a nurse on Boards. So this has to be recognised for an APC. We can't eliminate such courses or I'll start to say that I am not a nurse – I don't want that to happen – we must retain flexibility and recognise that nurses will end up in a variety of places and in my case I require an APC – I make clinical decisions that are nursing based.

(Mathias, 2:4)

Competence to practice sits alongside the issue of standards of practice. Heightened awareness of the need for standards for the profession was triggered by the visit to New Zealand of Professor Margaret Shetland in 1975, at the time concepts of autonomy and accountability were being hotly debated. Professor Shetland commented on the progress being made internationally in clarifying and redefining nursing functions, scope, and standards for practice. Standards for nursing practice based on the premise that the individual nurse is responsible and accountable for the quality of nursing care she provides. Watson (1995, p.7) cites Duff who in exploring issues surrounding standards of care and accountability suggested that

Standards of care are one way in which [internal accountability] is being achieved. This has led nursing to derive clearer definitions of those things for which it has authority. Without this it is not possible to see clearly what nurses are responsible and therefore accountable for.”

(Watson, 1995, p.7)

Following Shetland's visit, the NZNA recognised there was a need for guidance and direction for nurses in New Zealand and began work on generic standards for nursing services, nursing practice and nursing education and associated guidelines for their use. This led to the

publication of the first of a series 'Standards for Nursing Services' in 1978, 'Standards for Nursing Practice' (1981, revised 1993) and 'Standards for Nursing Education' (1986 – revised 1994). Schools of Nursing offering post registration education began to include the concepts of 'standards' and 'quality assurance' in their programmes.

Nicholls (1977) an American nurse educator, expressed the concern that as teachers of nurses, their students were rarely able to define the word 'standard' or to identify a safe minimal standard of care without direction. These nurse educators emphasised the need to differentiate between maximum standards of care and the minimum safe standards needed in order to achieve legal standards of nursing practice (Nicholls & Wessels 1977). This is a tension for some New Zealand nurses who want to provide 'excellent care' while funding will only support minimum safe standards.

It is interesting to link the concepts of standards in the sense 'best practice' and 'practice autonomy'. Kinross et al (1976) suggested that there was little chance of development of degrees of excellence in practice while nurses continued to operate primarily as safe supervised practitioners in a work structure with rules and regulations that prevent deviation from the norm. Excellence in practice could only develop once R.Ns were willing to accept responsibility for the quality of their practice.

Yvonne Shadbolt addresses this issue as follows

If the policies are best practice as determined by nurses, nurses are working autonomously if they practice to those, and I think that is the way in which you can more likely practice autonomously. That is to make sure that the framework in which you work, regardless of the organisations values, recognises and...assesses the practice in terms of standards based on best practice.

(Shadbolt, 2:9)

The issue of quality and quality assurance was widely applied to clinical practice in the 1980s both internationally and in New Zealand. Ways of strengthening the provision of quality practice included individualised patient care, identified specific standards of nursing practice, peer review, involvement of consumer groups in working with professional groups, and the certification of nurse practitioners. A number of methods of auditing quality had been developed by this time including nursing competency ratings, scales for measuring the quality of patient care, and retrospective audits focusing on patients' perceptions of the care they received (Phaneuf, 1976; Passos, 1973; Stevens, 1972; Wandelt & Ager, 1974; Wandelt & Slater, 1975).

In the 1990s the focus on health outcomes, performance measures, evidence-based practice, and accreditation of organisations all add to the ability to measure quality.

This section has explored some of the tensions raised for the individual nurse and the profession when considering an exploration of the terms and the contextual influences on an emerging understanding of autonomy and accountability.

How did an understanding of autonomy and accountability develop for the participants?

How an understanding of accountability and autonomy developed for some of the participants is illustrated in the **second** content area by exploring the careful reflection and experiences of the participants. The participants referred to issues related to this developing sense from the perspective of the profession as a whole, as well as from their own individual viewpoints. It was enlightening to travel alongside as the participants explored and grappled with these important and often misunderstood concepts.

The participants have changed over time (or as one of the participants commented ‘matured’), in their own understanding of what these terms have meant to them in the context of nursing. Several participants perceived difficulties with understanding the terms within the profession as well as individually and all had clearly given thought to the concepts and their complexity.

Sally Shaw suggested that whether we really have autonomy as a nurse depended on whether we were talking about ‘we’ individually or ‘we’ as a collective, the individual nurse, or the profession as a whole. While perhaps we can discuss autonomy in a collective sense (professional autonomy) when we look at autonomy in an individual sense, are we really including the idea of accountability?

I think that some of that writing [about autonomy and accountability] has been in the collective sense. That it's often talked about nursing as a profession being autonomous from the mantle of medicine or whatever. It is autonomy of making decisions in nursing and not having other people make them for you - sometimes I think that's it – autonomy in a collective sense that's important. But...there's the different focus – autonomy in an individual sense...I think in some ways it is more a matter of whether you're prepared to accept personal accountability.

(Shaw, 2:4)

Yvonne Shadbolt and Marie Burgess both commented on the question of individual interpretation, linking autonomy, and accountability together to some degree. Wade (1999) claims that definitions of professional nurse autonomy are inferred or loosely explicated, leading to ambiguous interpretations. She suggested that autonomous nurses are accountable for their decisions, feel empowered, and may influence the professional satisfaction of nursing.

Yvonne Shadbolt outlined her own difficulty with the word 'autonomy' and her perception that this might be the case for others as well.

I have some difficulty with the word 'autonomy' and what it means when nurses use it – and I rather suspect that no two nurses mean the same thing. If you take the dictionary definition of 'autonomy' as 'self governance' then in one sense you're almost back to using it as a synonym for accountability and that is that you act on the basis of what you think is the ethical, professional, appropriate way. You govern yourself to work within what you believe is an appropriate set of standards of best practice...In that sense I see autonomy and accountability as really synonyms and I think that most nurses when they talk about autonomy really mean accountability - governing one's own practice within a set of perceived and accepted standards.

(Shadbolt, 2:6)

Marie Burgess expressed the need to be clear about our meaning of the term, and also linked the two terms (autonomy and accountability) together.

We need to be clear about what we mean about 'autonomy'...If we're meaning a sense of being accountable for our own actions...with an aspect of independence associated with that...I think that [understanding] came later because it was a long time before we escaped, or ceased to accept what was very common parlance then – it was the doctor who carried the ultimate responsibility and so while we might be accountable for our actions at one level, we weren't accountable in any really autonomous sort of way.

(Burgess, 2:3)

Ann Nightingale suggested that as the transfer of nursing education got underway, deficiencies began to show up regarding what it meant to be a professional person in terms of accountability.

Beginning to discern what the responsibilities of a professional person are – what that means both as an individual and as a profession

(Nightingale, 1:6)

Ann spoke of the time in the late 1970s and early 1980s when a lot of this thinking needed to be crystallised for the nurse in New Zealand particularly in regard to discipline.

In the past Principal nurses had relied on the Nurses and Midwives Board to do the disciplining of their staff. Many times people were in front of the Council for what was a hospital systems failure. There were big deficiencies in hospitals in terms of professional discipline and managing their staff effectively and appropriately – understanding what it meant to be an employer and what was the difference between an employer and a professional organisation. We had to do a lot of re-educating at the Council end of the Principal nurses – what should and should not be referred to the Council for discipline. Principal nurses found it very difficult to make professional decisions as an employer.

(Nightingale 1:6)

This exploration of the individual nurse and of the profession as a whole in relation to autonomy is an interesting one. Moloney (1992), claims that autonomy can exist, on both an individual and a group level. On an individual level the claim is made that discretionary decision-making is crucial to autonomous practice (Lewis & Batey, 1982a; Benner, 1984; Holden, 1991), and that the primary consequence of autonomy is

accountability (Wade, 1999, p.312). On a group level Chitty (1993) suggests that aggregate professional autonomy which encompasses attitudinal and structural dimensions, is the socially and legally granted freedom of self-governance and control of the professional activities without influence from external forces. Is absolute aggregate professional autonomy realistic with the growing involvement of so many other groups in the care of people?

The research clearly separates out the two concepts, with accountability firmly linked to personal responsibility for action, while autonomy has a broader meaning linked to decision-making and the question of 'freedom to act' in relation to practice. The questions raised by participants of how this is affected when we are working in a collegial/partnership model made me pause, and as the material sources were explored through the contrasting views of individuals and the profession as whole, new understandings continued to emerge.

Margaret Bazley saw autonomy and accountability as '*varying things*' but focused on accountability as being responsible, particularly in relation to legal accountabilities. The importance of this was reinforced for her when the State Sector Act came into law.

I've always felt if I'm in charge of something that I am responsible for it. I've always checked the legal boundaries –you know, even when I was [working] in hospital I always knew the legal framework that I worked in. That within that, I was responsible, and I always expected that if I did something really terrible that I would lose my job or if it was too ghastly that I would go to court. I have always been mindful that there are penalties if you don't do things properly and I often think that perhaps a lot of people don't see that...

People get quite shocked when you confront them with the penalties and you realise that they've thought you can do anything – and the world isn't quite like that...The issue of accountability really came to the forefront for me with the State Sector Act, [in 1988]...I am absolutely accountable to the Minister for the running of this department and I hold all my staff right down to the frontline – they all have that accountability in their job description and performance agreements so everyone in this department [Social Welfare] is held accountable for their bit of the action.

(Bazley, 2:4)

Several participants mentioned the change in their understanding of the meaning of accountability and autonomy over time. Sometimes talking about when they first became aware of the idea – a turning point as it were - while at other times the awareness was more gradual associated with individual maturity. The beginning of an understanding and personal interpretation of autonomy was remembered well by Jocelyn Keith recalling a particularly significant and moving moment in her student days.

That [particular experience] was the beginning of autonomous practice for me – but it was nearly the end of nursing for me. I had been working in ward three [a general medical ward] and I had an elderly female patient. I must have been nursing [as a student] about 5 – 6 months and of course in those days [late 1950s] we had no intensive care or coronary care units and this lady...required observations every ten minutes. I had been 'specialling' her as we used to then the whole evening shift. We were doing very well she and I, I thought...She had my total and undivided attention and at 11 p.m. when the evening shift came on there was no-one to continue specialling this lady.

The night staff was going to be looking after her as well as all the other patients in the ward. I said well that was all right I'd stay until they could find somebody, and about 3/4 hour later the night supervisor came up and told me to go off duty and I said 'Well I will just as soon as someone else takes over'. She wasn't pleased and about three o'clock in the morning someone came up from theatre - theatre wasn't busy and I went off to bed...At about 7.30 am the home sister was banging on my door asking if I had a clean uniform and a whole pair of stockings because I was to be in the Matron's office at 8 a.m. So in between my bed and the Matron's office, I was reviewing my career options in a big way you could say. When I got there, Miss L. [the Matron] stood up to meet me – she was about ten feet tall and getting taller by the minute. She said that she understood that I had caused some difficulties in the night but that she would be interested to hear what I had to say about it before she passed judgement. So I just explained to her that I had been caring for this patient. I believed the patient needed a nurse for the night and I was prepared to be that nurse until such time as someone else could be. She looked down from her now about twelve feet high and said 'and you nurse need some sleep - back to bed'. I never heard another thing about it since and I'd have done it again, I think that's when you suddenly realise – I had a responsibility for that patient that overrode my duty to the Night Supervisor.

(Keith, 2:7)

I too remember specific occasions where an 'ah ha' occurred, a 'turning point', called an 'interpretive turn' by Smith (1990), and again those valuable assets/skills of critical thinking and reflective practice come to mind. Nurses need to recall and learn from those valuable experiences. Bem (1972) and Schon (1983) in discussing self-monitoring, and reflection-in-action, emphasised the potential when thinking about nursing

practice – the how and the why, and avoiding the risk of continuing to behave according to custom and practice routines where these are not appropriate.

Awareness as a more gradual process was discussed with Nan Kinross who described how she relates now to people in relation to autonomy, responsibility, and decision-making, in contrast to the past. She described it as ‘maturing’ and learning over time based on roots laid back probably in childhood. She did however give an example of an experience in her early days in nursing administration emphasising the difference that sometimes exists between the theory and practice, and how ‘maturing’ sometimes builds on a specific past experience. Learning from the past, through the present, to the future.

*The essence of the things that I tried out as a Chief Nurse are I believe now at the centre of what I do. [For example] I learned a very useful thing...Well I was all fired up and fairly young ...and so I got the department works manager and I went up to the wards and we looked through all the wards and we decided – **we** decided - that we would in fact remodel all the offices. Well about two days later I got a round robin [letter] on my desk signed by all the ward sisters and that round robin said - ‘Dear Miss Kinross, we understand from your staff meetings that you were trying to get us to make our own decisions. We are trying to do this. We therefore feel that **we** should make the decisions about our offices and how they should be remodelled – not you’...Well I can remember walking down the corridor to P.O. [a senior colleague] and going straight through the ceiling. I was furious that they had dared to question me - now you see how far I’ve gone [from that time].*

P. stood there – I can see her now and she laughed and she said ‘Nan do you realise that they are doing exactly what you want them to do?’ and I said – ‘So they are’ and I turned around and walked back to the office. Now I’ve never forgotten that.

(Kinross, 2:13)

In exploring the meaning and interpretation of the concept of autonomy further, nursing seems to have moved in a circle over time. We have moved from the time of the autonomous R.N entrepreneurs of the early 1900s, with their focus on the patient whom they primarily cared for in the patients’ own homes. Moved on through to the mid 1900s, where nurse students, dependent on the system, were the dominant providers of care for the patients in general hospitals. Then on past the changes in nursing education and practice in the 1970s and 1980s where ‘practice autonomy’ of the R.N was significant using modes of practice such as patient assignment and primary nursing. We are now seeing another change at the end of the century. A change that takes us full circle in one way – to where the patient is again becoming the central focus, but this time the focus of the numerous health care providers making up a ‘team’.

The ability of the nurse to act autonomously in the sense of ‘total freedom to act’ is seen as less likely in the health care settings of the late 1990s where issues of partnership, alliances, teamwork, and collaboration are commonly discussed. Henneman (1995) suggests that the attempt by nursing to find its unique contribution to patient care has actually created a barrier to collaboration.

The fact is that other health professionals also share the metaparadigm concepts of person, health, and environment. It seems that nursing would be better served by acknowledging shared paradigms than trying to isolate its own.

Again adoption of the philosophical approach, of defining a unique paradigm, has hindered a spirit of professional interdependence and collaboration.

(Henneman, 1995, p.361)

This question of professional interdependence was acknowledged by many of the participants. Ann Nightingale thought that we hadn't yet clarified what working collegially or intercollegially meant and what our professional responsibilities were, particularly separating out our own professional role from designated medical tasks.

Nurses can't always distinguish their own professional role and the difference that makes...how it blends in with others roles, how to use themselves therapeutically...all professionals have a contribution to make and we need to understand the worth of each other and use the skills of each other.

(Nightingale, 1:4)

Mia Carroll spoke passionately about her feelings concerning professional collaborative practice as outlined in her vignette later in this chapter, and Yvonne Shadbolt questioned whether anyone really acts autonomously in any health care setting.

It is extremely difficult to see how anybody acts autonomously— as a professional - in most of or any of the practice settings I know. Even the independent practitioner who may make autonomous decisions about their business, acts, and is governed by the legislation, economic imperatives, a whole range of other things. So perhaps the concept of self-governance – free to make decisions that are yours and yours alone, is almost inconceivable – I cannot conceive of a setting where it would occur or be appropriate in any way.

(Shadbolt, 2:6)

Nan Kinross in outlining how her concept of autonomy had changed over time, emphasised the movement from the idea of individual autonomy in respect of decision-making to collective responsibility and dependence on others for feedback.

I've gone through the whole gambit. I've gone through a whole lot of development on this one I think. Western philosophy says that we are individuals and individuals are autonomous and so on and so forth. So my original – I suppose my stance for many years was that the individual was important – that the individual was autonomous, that you in fact you needn't necessarily be right, but there – you could in fact make decisions on your own. Now gradually I came to see that indeed I think is a false position. You don't ever make decisions out of the blue – on your own, in a vacuum. You in fact are very dependent on other people to give you feedback.

(Kinross, 2:10)

Nan also recalled the exact situation that triggered for her the need to reflect again whether we really ever act on our own, what individual autonomy really means.

The thing that really really made me think was when I became Chair of the Ethics Committee of the Research Council...We went to a Marae with the Maori health committee...We were busy talking away about collective decision-making and individual decision-making and how ethical decisions are made and she [a member of the health committee] says to me – 'Nancy' (she'd

*known me a long time) 'Nancy, if there is a Maori person who has AIDS and who dies, what do you do about the body? Is this an individual decision (and he says he does not want his family to know)?' I looked at her and I could see that I was going to be in real trouble – so I said 'You know – my background, which is European, tells me that this is an individual decision and one should respect the right of that individual'. 'Yes' she said 'but for Maori that body belongs to the family - it does not – you cannot **not** involve the family...Now this really dented my whole business about autonomy badly because I realised that in fact there is really no such thing as an autonomous kind of thing. You do not ever operate on your own...well you do but your decision impinges upon other people so I now have this concept of collective decision-making, and that is particularly true when you are dealing with people who are very ill...[For me I think] the concept of autonomy in health has been quite severely dented.*

(Kinross, 2:10)

These examples of developing understanding of autonomy and accountability have highlighted several points. The need to consider the difference between individual and professional autonomy; the way we use the term autonomy; when we use the term autonomy and sometimes mean accountability; the links between the idea of autonomy and professional interdependence.

While exploring these concepts with the oral history participants, I also asked them how they assisted and supported others to practice autonomously or to understand the idea of accountability. Chalmers (1995, p.47) suggests that accountability thrives in an atmosphere of support, challenge, encouragement, mutual respect and trust. To be accountable frequently demands that difficult questions are asked, and there must be a climate for working that facilitates this. This would

indicate to me that we as nurses need to create that climate, we need to provide that supportive environment where nurses are not afraid, where nurses gain confidence in themselves, where nurses work as part of a team sharing their experiences and learning and supporting each other.

Chalmers (1995) cited Curtin (1982, p. 48) who saw the major battle for the acceptance of accountability to be among nurses themselves – “If this battle has now been won, then a significant hurdle has been crossed in the struggle to get nurses themselves to value nursing and to value their role as accountable practitioners” - a very interesting point for us in New Zealand in the late 1990s. The question of valuing nursing and valuing each other is still unresolved here. It is also an issue internationally, with ICN preparing position statements to assist the profession develop strategies to clarify the value of nursing for others.

So how did some of the participants support others to ‘cross the hurdle’ to value nursing and their role as accountable practitioners? Mia Carroll outlined some of the plans she had to create an environment that would avoid nurses moving back to rigid rules for no reason, and stopping those nurses in positions of authority thinking that just because they said something, that it is right, set in stone.

*I want to create the environment where even if **I** say it [as the senior nurse in the institution], the norm is that you will challenge based on evidence...I think that whole business has possibly – its put us in an ‘angst’ position – it has breed a culture too of a lack of tolerance for multidisciplinary collaboration. [For example] how dare a speech language therapist tell me when somebody can swallow – I mean **I know**. You know it’s built a possession of this is mine, my knowledge. [It has] strengthened the turf disputes instead of weakened them I think.*

(Carroll, 2:7)

While I personally support multidisciplinary collaboration, my reading around the concept of 'collaboration' suggests that this is another complex idea or concept with different meanings for different people and situations. Styles (1982), reflecting on collaboration and unification noted that doctors often felt threatened when nurses discussed collaboration, perceiving the process as invasion of their position of authority and power. Several writers internationally and in New Zealand comment on their perception that nurses and doctors mean different things when they consider 'collaboration', especially in relation to who is in charge, who is the decision-maker (Clinton, 1987; Katzman & Roberts, 1988; Mathias, 1987; Roberts, 1983). Nurses and doctors and other health professionals will certainly need to reach a common understanding of the term if the patient is to be the beneficiary of 'collaborative practice'.

I have found the theme, 'an emerging understanding of autonomy and accountability' fascinating, as there really did seem to be a sense of development, of ongoing exploration, of changing perspectives and maturation of ideas building on the ability to make decisions. There really is no agreement about a collective understanding of the terms. Nurses still interpret and give meanings to the concepts from a wide range of perspectives. While in itself this is understandable and highly likely to occur in a young growing profession, I believe we have much still to do to collectively explore the ideas, and ensure that we do not provide premature closure to the debate in an ever changing environment.

The revelations outlined from the written and oral texts have laid the foundation for an exploration of the development of autonomy and accountability as seen through the changes in the attitudes and beliefs of the R.N from the 1960s to the 1990s. While the exploration of terms and an understanding of the contextual influences has been important, the changes in attitudes and beliefs was even more significant as the influence of the profession and the individual nurse become more transparent.

Changes in attitudes and beliefs associated with a developing sense of autonomy and accountability.

In this **third** content area the participants' accounts reflect their individual struggles with the concepts of autonomy and accountability over time and the need to change some of our attitudes and beliefs if the nursing profession is to ensure the continuation of the primacy of the nurse. The first two content areas in this theme chapter focused on an extensive exploration of terms associated with autonomy and accountability; the contextual influences of structural change, working alongside others, and 'control' of professional development; and how the participants struggled with the concepts and changed their attitudes and beliefs over many years.

Realising the importance of autonomy and accountability to the growth of the profession and to individual professionhood, the next two content areas reveal more about the changes in attitudes, beliefs and responses associated with a developing sense of professional autonomy and accountability, and individual accountability for our own decisions and actions. The participants' experiences highlight the importance of confidence and self-belief, the cycle of independence, dependence, and interdependence of the nurse over time, and our use (or lack of use) of 'voice'.

Self-belief and confidence

Sally Shaw (1989), in her paper titled 'Mind over mind set' referred to earlier, asked the profession to address the challenge in times of extraordinary change and to seize the opportunities to alter the stereotypes of nursing, to strengthen nursing power bases, and to consider opportunities for self-governance in nursing and the development of autonomous practice. This paper had considerable impact for many nurses at this time helping them explore their own attitudes and beliefs, and

illustrated how significant self-belief and confidence are to our ability to be actively responsive to the issues of the day.

Self-belief is a cornerstone in understanding autonomy and accountability, particularly in developing confidence in an ability to accept responsibility, and to make decisions relating to practice. Ingeborg Mauksch (1977) an American nurse academic believes that accountability is the highest level of risk taking – being answerable for your actions, and realising that responsibility can be scary as your actions are perused and examined by others. You need self-belief and confidence to be a risk taker. In her short personal biography published in 1988, Mauksch commented on how her experience teaching medical students showed her “how much more autonomous they were than nursing students.” This raised her interest in finding ways to intensify nurses’ sense of identity and self worth (Schorr & Zimmerman, 1988, p. 57).

Jocelyn Keith pondered on a comment from a non-nurse doctoral student about nurses’ preference to be employed by others rather than move into dependent practice even when the opportunity was there. She wondered whether this went against autonomy and accountability.

Nurses either don't want to, or are not able to take the risks that are expected. Nurses seem to prefer to have someone else make the decisions for them[especially] about their jobs. So while we are preaching autonomy and accountability and decision-making in practice in our work, when it comes to our lives, we're not exercising the same degree of independence.

(Keith, 2:11)

Even the possible changing and expanding of the nurse’s role in relation to accepting responsibility for prescribing medication is perceived as threatening for some. The lack of collective action in this context is very similar to the lack of exercise of ‘positional power’ or influence in times

of change mentioned earlier in this chapter, the question of non-use of opportunity.

In times of opportunity the question arises - What is the greatest risk? To seize opportunities individually and collectively and move forward, or risk nothing and stagnate. To be able to make decisions, to accept responsibility and accountability for those decisions, and to take risks, needs a degree of self-confidence and this attitude seems to be missing for many individual nurses. Several of the participants would suggest that this is significant for the profession as a whole.

Sally Shaw believed very strongly that this issue of confidence was really significant, and in several quotes set out below used examples from her international work, applying both to the profession and to individual nurse. When discussing how the concepts of decision-making and autonomy arise in her international 'Leadership for change' programmes, Sally said that while these concepts arise over and over again, confidence was the most important issue.

What it comes down to as the basic [leadership] ingredient in every country or region where I've worked [South America, Caribbean, Asia, and Africa] is a matter of confidence. And over and over – whether they are nurses in senior positions or new leaders emerging or whatever it is – it's a matter of confidence.

(Shaw, 2:8)

Confidence can be explored at two levels - confidence as a concept associated with the development of the profession, and confidence associated with the developing individual. The development of professional confidence is expressed in the policies, standards, and stances taken by the profession as a whole. For example, nursing curricula were first developed using models and theorists from overseas. Indigenous theories of nursing are now developing, and the New Zealand concept of

‘cultural safety’ leads the world as a contribution to the understanding of the health needs of first peoples. Sally saw confidence at two levels too, and outlined the significance of confidence for the profession as a whole.

I see that [matter of confidence] at two levels. One is self-confidence, and the other is confidence in the image of nursing - how nursing is perceived by others. So one of the themes that people find most important, and most difficult, is how to articulate the value of nursing to other people. Over and over in other countries they say that...if they are going to be part of the decision-making process...[you need] to be able to articulate to others what it is that you have to say, what contribution nursing can make.

(Shaw, 2:8)

The significance of the image of nursing as seen by others reflects again our lack of confidence. We are not able to go out there and tell the world how valuable we are, what a great contribution we make, despite those outside of nursing often saying it for us. Ann Nightingale also spoke of the effectiveness of this group who were in strategic positions around the country and stimulated activity everywhere. Sheryl Smail, when she was the Chief Nursing Officer in the Department of Health, reinforced the importance of nurse leaders increasing their visibility. She quoted from the publication of an international conference on leadership in nursing held in 1986.

If nurse leaders are to become visible, they will have to move out and establish lines of communication through a variety of channels to other professionals and the general public. The majority of leaders in nursing still operate intra-professionally, tending to

communicate only with others like themselves, at meetings of nurses, through writing for professional journals or when debating nursing issues.

(Smail, 1989, p.10)

This need for nurse leaders to have the confidence to move out – to participate in the wider health environment, was emphasised by Sally Shaw describing the importance of nurses being able to express their point of view, and how some international leaders in nursing still lacked confidence and needed help and support to grow especially in the wider health environment.

[We talk about] why nursing should be at the top table for policy and decision-making, and I think that many nurses don't feel comfortable because in many countries they perceive nursing as other people perceive it. So if other people say – that nursing has a bad image, or whatever it is...It will reflect on them and it demoralises them and they feel it even harder to go and project something positive and proactive in that environment.

(Shaw, 2:8)

Sally described how limited many nurse leaders appeared to be outside the nursing environment, and this in some way helped explain why the profession as a whole fails to reach the potential seen so clearly as a possibility by international leaders in the health sector.

*But I think that there's another thing it seems to me, and that is that nurses have often been very confident and articulate in a **nursing** environment but you put them into another environment like...health executives or multidisciplinary with doctors, other professional groups, management of another kind, and they often shut up.*

And you see it over and over again – then they'll go away and complain about everything that was said and done but haven't necessarily provided any input themselves and they say that they don't feel confident in doing it outside of an environment of [nursing] peers (that they really know)...Sometimes confidence is a matter of practice and achievement. So the more you do different things...the more confident you feel.

(Shaw, 2:8).

Sally also spoke of the negative effect on participants in her programmes when they were not involved in decision-making, if they haven't had some good successes, if decisions they had made were perceived as having a negative effect.

Then they don't have the confidence to move ahead, and they don't become practised because they will retreat from being involved in that sort of thing at the very time that they know it is important they should be there.

(Shaw, 2:9)

However if they practise more, and are asked to participate in national policy because they are now considered to have something to say, things are different. Sally spoke about the change in some of the participants in the Leadership programme over time.

At our recent meeting in Argentina, I was talking with a group of people [from several different South American countries], who had been in our phase one programme. They said they're nearly all into exercise programmes – swimming or walking, they are looking after their health, they're feeling better, they are doing more, they are learning to get a better balance in their lives and they are taking on even more challenges than they thought they would have before.

And some of them openly say – ‘two years ago I would have run a mile before ever getting involved in that e.g. media activities. They said they just would have said ‘I’m not available’.

(Shaw, 2:9)

Growing and developing confidence can lead to a change of attitudes and belief in oneself, utilising effective decision-making, accepting accountability in a context of professional autonomy and increasing personal effectiveness.

I’m struck over and over again by the number of people in different countries who talk about confidence, and I’m struck about – when I’ve worked with a few of them as I have over the two years how you see them glowing as the confidence grows...So it’s all of those things – having a sense of autonomy over self, because it comes with confidence in self, it’s growing comfort with your decision-making, it’s being accountable, and it’s helping them to get into the driving force bit. To become more of a proactive, dynamic driving force than maybe more passive as some of them were before.

(Shaw, 2:9-10)

Attitudes are particularly influential in the way we think and act. How the profession sees itself and how individual nurses see themselves in relation to confidence both as a collective and individually will clearly impact on how we exercise autonomy and accountability. It would appear that individual nurses can demonstrate clearly their confidence and belief in themselves, but the profession as a whole still needs to develop a sense of confidence particularly related to policy and participation outside of the nursing environment.

Independence, dependence, interdependence

The changes in beliefs and attitudes of nurses in New Zealand can be seen clearly over time linked to the ideas of independence, dependence, and interdependence. This exploration includes links to the influence of medicine, and the bureaucracy on the profession as a whole, and other attitudes raised by the participants that encouraged dependence including the limiting notions of 'fear' associated with being accountable, and the impact of a lack of courage. In contrast, as a sense of independence developed, the notion of 'personal comfort', and the belief that 'nurses can do anything' illustrated growing confidence in both the individual and the profession. The next step was the challenge of interdependence.

Understanding the effect of the hierarchical structures common in New Zealand in the 1960s and 1970s made it easier to reflect on how we were slow to see the dangers inherent in continuing to accept delegated power from both medicine and hospital administration as a suitable base on which to build a professional [nursing] career structure (Kinross, Chick, Thomson, & Pybus, 1976).

McCloskey (1981), an American nurse, wrote about the move from independence to dependence by the nurse, in terms of the power and control over nursing by both the medical profession and the bureaucracy.

Historically nurses functioned as independent practitioners and their power was visible and obvious. In the early 1900's nurses and their skills helped make hospitals safe for patients. Nurses in public health helped to prevent illness and lower mortality rates through the application of their scientific knowledge. Very often it was the nurse – as independent practitioner in home, community, and hospital who kept patients alive and comfortable when medical or surgical therapies had done all they could.

(McCloskey, 1981, p.6)

This international trend occurred in New Zealand too, but overtime as the need for more ‘carers’ developed, employees (mainly students) essentially became the property and impressed labour force of the hospital. They began to become dependent and in their training were taught that they should display unquestioning obedience to the doctor.

Internationally some nurse writers also suggest that exercising authority and accountability has been made more difficult for nurses by the attitude of the some of the predominantly male medical profession. Dunkley (1975) in a paper presented at a combined NZNA and ANA conference asks the question ‘*Physicians assistant – why not!*’ She suggested that in the year of 1970 there was a beginning awakening in the nursing profession in the USA to medical authoritarianism and male dominance and the fact that whether or not we are aware of it, men make the really important decisions for nurses and nursing.

Rothberg (1973) writing on a similar topic in the same time period, identified the issues associated with delegated medical tasks as independence versus dependence; male versus female; dominance versus submission; medical care as differentiated from health care; control in contrast to freedom.

The dominant approach of the medical profession in the 1960s and 1970s was widely reported in the overseas literature. For example in the USA, in 1970 the Executive Vice president of the American Medical Association, Dr. E. B. Howard had suggested that with only modest additional training, nurses could become associated with physicians in such a way to expand the physicians ability to serve his patient. In response the President of the American Nurses Association at the time, Dorothy Cornelius, stated that “It is not the prerogative of one profession to speak for another” (Dunkley, 1975, p.17).

Stein, Watts, and Howell (1990) updated Stein's classic article '*The doctor – nurse game*' written in 1967. They noted the effect that higher education and defined areas of practice expertise had had on the nurse, and suggested that they [nurses] functioned more autonomously within the health service than two decades previously.

While nurses might believe that they functioned more autonomously, this was not always the perception of the medical profession, and the debate about the relationship of the two professions and their various responsibilities, accountabilities, and autonomy, continues even to this day. The examples set out below illustrate this well.

In Australia, McCoppin (1994, p.133) suggests that the acceptance of accountability by the nurses is "perhaps made more difficult...by the longstanding attitude of medical practitioners that it is they who make the orders for nurses to carry out and it is they who are accountable." Some doctors still believe that they are responsible for the actions of the nurse, which enables some nurses to think they can hide behind vicarious accountability in spite of the legal requirements which make the nurse accountable for her own actions. A participant in McCoppin's Australian study, when commenting about why the accountability of nursing staff is not accepted by the medical profession had this astounding comment.

It's a threatening concept and doctors aren't taught about it in their courses. I was arguing at an ethics committee over informed consent and professional accountability and the medical members not only didn't, but refused to acknowledge that nurses had any degree of accountability at all...They find it surprising that not only do other disciplines learn these things in their courses but that they understand them...Doctors have been disadvantaged by their education.

(McCoppin, 1994, p.133).

In New Zealand, Clinton (1987), a nurse academic, described a classic debate in the New Zealand Medical Journal between a nurse (who happened to be Lee Mathias) and members of the medical profession. Clinton outlined how while the nurse described the nursing process as holistic with 24-hour accountability, one doctor described the notion of 24 hour accountability in nursing as a 'piece of fiction'. The doctor also took issue with the process of nurses identifying health-care deficiencies – 'creating them more likely' was his retort.

Ann Nightingale provides an interesting personal experience in the late 1980s with a senior consultant who stated quite categorically that he was responsible overall – he was responsible for Ann and what she did.

So he was told in no uncertain fashion what he was responsible for and what he wasn't...they [doctors] couldn't come to grips with that at all. There is a lot of work yet to be done both for nurses and doctors on what professional relationships are about – what professional roles are, where they meet, and where the decision-making point are.

(Nightingale, 2:1)

In May 1999 the New Zealand media carried a story of the perceived lack of accountability of the medical profession during a series of enquiries relating to the alleged substandard performance of a pathologist. Six investigations over a five-year period criticised the pathologist but nobody alerted health authorities. One of the women concerned is quoted as saying, "Accountability would be nice." (Barber, 1999, p. A5), and the Minister of Health "Wants to know if a law change is needed to prevent secrecy when public health is at stake"(Corbett, 1999 p. A1).

Attitudes raised by the participants as barriers to accountability included the limiting notions of 'fear', and lack of courage. Mia Carroll introduced the notion of 'fear' associated with being accountable, expressing a

concern that we are not ‘breeding a climate’ to assist nurses be accountable.

I think the ‘fear’ that people have around being truly accountable is vast and completely understated. If they could recognise the link between accountability that’s shared and/or collaborative, versus the accountability that stems from ‘my being a staunch banging on the door autonomous practitioner’, the fear might go a little. But I think there are very few people who are truly prepared to be accountable for their decisions [and for] their actions and for their interventions. We’re not breeding a climate where we make it easy for them.

(Carroll, 2:12)

This attitude of ‘fear’ further illustrates the need for preceptorship, and mentoring so we can develop a climate where peer review and collaborative practice are valued for the knowledge and experience that can be offered both the individual and the profession as a whole, rather than being seen as threatening. Jocelyn Keith recalled times when we failed to contribute because we lacked courage, and realise later that perspectives from a nurse would be valued.

People will say to you ‘why didn’t you say something before’, and you feel slightly ashamed of yourself because you could well have [contributed]. You just didn’t have the courage, and that’s why I said about ‘belief in self’ and ‘belief in nursing’ [so important, such potential].

(Keith, 2:14)

This need for ‘courage’ is an important concept that has been raised in both theme chapters so far and is dealt with in more detail in the chapter on nurses as a driving force.

The developing notion of 'personal comfort' mentioned by Sally Shaw is another example of the maturation of a personal sense of autonomy and accountability— as over time we learn to trust ourselves to delegate and to trust others to exercise professional judgement. Sally discussed the developing notion of 'personal comfort' for her as she assisted others to accept responsibility

You sometimes find it harder to encourage other people to be independent, to make decisions of their own, because you feel responsible - accountable if you like and I think it's only in more recent years that I really developed a sense of 'comfort' in other people that worked 'for' me making decisions that might be different from what mine were, of doing things in different ways but focusing on the outcome rather than the process. I think in the early days when you take on positions of responsibility you're a bit hung up with process because that's the way you're taught —we had procedure books and rules and regulations, but later on there comes a greater degree of comfort. For me, I don't know if it came earlier or later, but I remember being conscious of it later an absolute degree of comfort and worrying less about the process in some things...Giving people the real freedom to do things their way so long as that was reasonable and that the outcome was really what mattered.

(Shaw, 2:4)

As the participants have revealed, not only do we need to be more aware of our personal attitudes and beliefs, but also we need to value involvement in the wider activities associated with nursing by increasing our ability to be confident and effective. The history of dependence on the medical profession, the need to accept legal accountability, the impact of fear of the responsibilities associated with autonomy and accountability and lack of personal courage are important to understand as both the

profession and the individual nurse move towards being more positive about our ability to contribute ensuring continuation of the primacy of the nurse.

One important factor that has the potential to still limit our contribution is how we use or fail to use our 'voice' in both nursing affairs and wider health and social policy.

The nurse's voice (or lack of it!)

In the 1960s and 1970s the *NZNJ* and papers presented at national fora, were full of editorials and speeches exhorting the nurse to 'speak out', to 'put their ideas in writing', to 'be ready to answer the questions', to 'be involved', 'to collectively take courage' (Cameron, 1960; Chambers, 1960; Holdgate, 1969; Holdgate, 1973; Hollis, 1964; Orbell, 1971; Sears, 1980).

Leaders in nursing over these two decades sought to encourage nurses to voice their opinion – their attitudes and beliefs about the major education and practice changes likely to occur. In 1964, looking back over the past year in her statement to conference, the NZRNA president stated her view regarding the voice of nursing very strongly. "I cannot too strongly emphasise the importance of the nursing profession deciding its own destiny." (Hollis, 1964, p. 4). Here was a leader accepting the need for the profession to move forward and acknowledging that nurses needed to be part of the decision-making. In the same speech she deplored our inaction – our lack of progress - and asked the question "Is there apathy within our ranks?" (Hollis, 1964, p.4).

In 1969, the Director Division of Nursing, Shirley Bohm, wrote about changes ahead, and asked if nurses in New Zealand really wanted to continue with a 60 year old image of nurses as the Doctor's assistant, failing to identify aspects of nursing that are independent or self directed,

or to change to be a creative and constructive force requiring intellect, character, and personality leading to knowledge and skills and boundless respect and compassion for humanity (Bohm, 1969).

In 1971 the NZNA President in describing the unique opportunity for the profession to move forward suggested that there were valid reasons why nurses were hesitant to make their voices heard. These included conditioning, weariness, and apathy.

Since the day of Florence Nightingale they [nurses] have been conditioned to follow the policy that Saint Paul advocated in 1st Corinthians, Chapter 13 – ‘To suffer long and to be kind, to envy not, to be humble and not proud, not to behave unseemly, not to be easily provoked, to bear all things, believe all things, hope all things and endure all things.’...So weary have they [nurses] been with the pressures of the working day, that few have had the time nor the energy to look beyond the immediate present...There is yet another barrier over which it has not been possible to climb, and that is the apathy that has pervaded this profession for the best part of a generation. It is a peculiar thing, this element of apathy with regard to the future of the profession, in a group of women so earnestly and honestly devoted to the care and welfare of people...They are truly dedicated people - but dedicated to their patients and not particularly dedicated to their profession, if one can establish the dividing line, and it is curious to contemplate.

(Holdgate, 1971,p. 4)

I remember personally being at this 1971 conference and being very concerned at this picture painted by the NZNA president. In 1999 I am still concerned about the ‘voice’ of and for nurses.

The *NZNJ* nurse editor Ann Cherrington in 1984 reminded the readers of the consequences of apathy as the organisation sought to cope with a change in Government and a move out of a wage freeze.

History records times when crucial – and sometimes faulty - decisions have been made by a minority against the views of the majority. But often this has simply been a consequence of the apathy of the majority, who have no-one to blame if the outcome is at variance with their opinions.

(Cherrington, 1984, p.2)

In 1985 the nurses 'voice' was well heard in the 'Nurses are worth more campaign' (see chapter on 'Nurses as a driving force'). The late 1980s and early 1990s was a time when the voice of nurses was expressed primarily through the NZNA, as nurses struggled to adopt and adapt to the rapid changes in the health sector. Large meetings, protest marches, strikes, letters and articles in the *NZNJ* were triggered by legislation such as the State sector Act (1988), the Employment Contracts Act (1991), the Health and Disability services Act (1993), and events since then such as restructuring and closure of health services and facilities, and resignations and redundancies affecting experienced nursing staff and other health personnel (Dickson, 1992; NZNO, 1995).

In the late 1990s the message from the Chief Nurse Advisor in the Ministry of Health can be heard cajoling the profession to move, to take opportunities to make a contribute to the health of the peoples of New Zealand. The message to us as a profession is still the same as it was four decades ago.

The most provocative and persistent cajoler during the four decades under study was 'La Provocateuse' who wrote in the *NZNJ* in the mid 1960s. She was never publicly identified but did state that she was **not** 'a Wellingtonian, or a Matron, she did not have a university degree, was not

on a national committee. She was an 'ordinary' nurse'. In November 1964 La Provocateuse began her column as a regular contributor seeking to stimulate debate. She had this to say in a poem in the New Zealand Nursing Journal (with apologies to William Shakespeare)

Sorry, Bill.

Nurses, Sisters, Matrons all, prepare for this
I come to irritate you, not to flatter.
Does each day's work bring such exhaustion
That you are done so wearied, in your bones,
and emptied of all thinking? Let it be not so
But rather get you out to meetings
and have great talk, and be considering:
For there is much of import to discuss
and grieve we may if silent now we be.
Here, without your leave, and like it or not
(for you are too impassive anyway,
and need to be goaded into action)
Come I to speak and tell you plainly that
the whole country's talking more of nurses
and of nursing, than are the nurses
who should themselves be leaders of the talk.
Why do you fly away from print and press,
why shrink in modesty unnatural,
and let the uninformed hold every floor?
Is there no voice among you to speak out?
Tradition bids you hold your peace you say?
I ask you bluntly, "What tradition?"
The Nightingale was far from silent,
and still great store upon her song is set.
I think we do ourselves an untold harm
To hold our tongues in check. Too much tradition
bars progress; and too much silence smacks
of things concealed. Is this seditious talk?
Who shapes our image in the public eye/
who tells them what they surely ought to know
who gives the critic food for second thought,
who clears misapprehension and half truth?
It seems to me the answer's plain enough-
the task is here for every nurse.
Ignorance you dare not claim, for ignorance in
others
could yet deprive us of our chosen goal.

(La Provocateuse, 1964, p.11)

Responding, La Pragmatique supported 'Sorry Bill' and the need for the profession to "release its tradition-tied tongues" (La Pragmatique, 1965, p.29).

Throughout 1965 (and in 1966 in response to four letters in the NZNJ requesting her to continue), La Provocateuse endeavoured to provoke journal readers with topics like 'Battle cry' (Danger that we become so concerned about nursing issues that we forget the end – the patient). 'What's your score?' (Involvement in NZNA), 'Softly softly' (Noise in hospitals). 'Here we go round' (Ward rounds). 'A spinster weaving threads'. (The call has gone out to the married ones – come back nursing). 'La Provocateuse propounds' (General education intake/wastage is an overall national pattern, not just in nursing). Her comments on the apathy and lack of input of nurses were included in a September journal article titled 'Bakers dozen'.

It's a long time since 'Sorry Bill', the 13th article, and what have I accomplished – four replies! Nurses in New Zealand are too complacent, and I don't think anything could goad them into action.

(La Provocateuse, 1965, p.21)

She then decided to no longer write for the 'mute' audience and wrote that she gradually understood why nurses were so unresponsive.

Our Tutor Sister is just back from the psychiatric concepts course and trying to explain about 'silent communications'. And I have read in a magazine article the phrase 'don't do something: just stand there!' Obviously in trying to campaign for better nursing now and in the future, I have been too verbal and too vigorous. I will join the great sorority of those who stand and are silent,

Yours, Gagged, La Provocateuse)

(La Provocateuse, 1965, p. 7)

An *NZNJ* editorial in September 1965 suggested that the lack of response to La Provocateuse over the previous months meant that

Nurses prefer to lie wrapped in their snug little cocoons rather than venture out into the arena and face our fiery La Provocateuse. Is it sluggishness, lethargy, laziness or just plain indifference to what is happening around us, that is holding up some positive reaction to the varied balls sent into the ring by La Provocateuse? Whatever the reason, it is a dangerous sign...Constructive criticism and an exchange of views on controversial topics is desirable; it is expected from progress-minded people, and we expect nurses to be progressive in their thinking.

(*NZNJ*, 1965, p.4)

In December 1966 La Provocateuse gave up the struggle, and was heard from no more. I have not been able to find out who this amazing nurse was, but with sadness suggest that in 1999, if we were provoked again, our silence would be similar. The perceived non-assertiveness and apathy (in the sense of inertia), of nurses has often been linked to nurses lack of decision-making and perceived lack of autonomy in the sense of having a choice, the freedom to act.

International writers also speak of this affliction 'apathy'. In some respects I find this encouraging in that it is not 'just a New Zealand phenomenon', but in other respects it raises concerns. How can/will we create a nursing future that moves forward, and makes a difference, if we continue with this attitude, this 'epidemic' referred to in the quote below.

In 1984 the writer of an editorial in the *American Journal of Operating Room Nurses (AORN)* titled 'Know thy enemy', suggested that apathy is the enemy of professional nursing.

Professional nursing has an enemy ...The key to conquering the enemy is recognising it. The enemy of nursing is not restrictive institutional policies, partisan policies, hospital administration, or uncooperative physicians. It is not the DRG's [Diagnostic related groups used as a system of classification], unequal wages, or burdensome legislative processes. Apathy is the enemy. See it as it is. Given the least chance, apathy will always win, for it is sneaky. It usually has an insidious onset, can take control of an unsuspecting individual, and can develop into a chronic condition. It has been known to spread to epidemic proportions. It can disguise itself as a combination of hopelessness, laziness, and pessimism. Its victims become dispirited, unwilling to act, and easily depressed.

(Niessner Palmer, 1984, p. 939)

In 'recognising and conquering' this enemy the 1970s saw many courses on 'assertiveness training' offered to nursing staff by the then well established nursing inservice education programmes. It was exciting to see the change in some nurses and their increasing sense of confidence and self worth as they shared and learned together.

In the 1980s graduates from nursing education programmes believed that their education encouraged them to be more assertive and questioning, while the more experienced nurse was often still timid in her approach and certainly unlikely to take risks (Williams, personal experience). There was safety and security in the tried and true.

The importance of self-confidence, courage, an 'anything is possible' attitude, and commitment were raised by the participants when discussing the future of nursing or the legacy they would wish to leave to the next generation of nurses. Apathy is sometimes seen as the opposite to commitment. As professionals we value highly commitment and

involvement in the discipline of nursing. Throughout the decades we continued to express concern about lack of commitment and what this meant for the profession.

Anne Nightingale (1973) when speaking to an audience about a professional organisation, in her capacity as President of the NZNA Auckland branch, commented on the lack of professional involvement of nurses.

The development of any profession is dependent on the members of that profession. Unfortunately for us in New Zealand, too few nurses see their responsibility to their profession as existing outside the four walls of their ward or circumscribed area of work. Their day's work is the beginning and the end of their professional life. What they are missing! And what nursing in New Zealand is missing! Because these nurses are intelligent and able and capable of contributing immensely to the profession's resources. But because they are withdrawn, even apathetic, the professional association is deprived of ideas and means of development. I hear many complaints of what the association is and is not, of what it does and does not, and some of the complaints are valid. Many of them are made through ignorance of what has been achieved; and many times this ignorance is attributable to laziness...Many nurses excuse themselves from involvement by reference to how hard they work (which they do) or by complaining that nobody will take any notice of what they say anyhow.

(Nightingale, 1973, p.9)

In the 1980s as an educator in a large polytechnic with approximately 70 nursing staff, my personal experience over a number of years was very similar. When there was a request for serious discussion of professional papers or issues of the day, we could muster only about 10 – 12 nurses

with sufficient commitment to be sure we had our say. As an active member of NZNA and the education and research sections over this period, I found this personally frustrating because as Anne states above, we were missing out on valuable experience and helpful comment.

Marie Burgess expressed her concern in the 1990s for a wider commitment from nurses as a whole.

[The need for nurses] taking –having a greater commitment to the profession - being responsible and accountable for something wider than just – going to work...It always saddens me when I hear people say that it's just a kind of job, just going to do that and you think of all the issues and things that you could become involved in within the profession through the organisation or whatever. There is a tremendous number of issues related to patient care or to families in the community and it's sometimes disappointing that members of the profession are just not interested - in making a mark. I think we are a tremendous force for good if we are interested, but it does take work outside working hours and sometimes that's too much for people.

(Burgess, 2:12)

This lack of response from the profession was demonstrated in 1998, when the Ministerial Taskforce on Nursing called for input from New Zealand nurses and more than 30,000 one-page questionnaires, with covering letter explaining the Taskforce's terms of reference, were mailed out to individual nurses through existing networks. 1137 submissions were received in response to the mailout (Ministry of Health, 1998, p.91) (Some would have been group responses but not large numbers).

What influences this attitude of perceived non-participation on the affairs impacting on our future? Is it because we as nurses are a predominantly female workforce with many responsibilities both at work and in our

personal lives, or is that a convenient excuse? Do we have too many conflicting priorities? Are we too demoralised because of the perceived constant change in every aspect of our lives? Are we too much into a 'victim' mode to see that we have choices? Are we any different from the public at large in our reluctance to get involved with issues of the day? Attitudes and beliefs can be infectious and the evidence from this study suggests that individually and collectively we still have much work to do to counter our 'lack of voice' even when issues concern our own destiny.

The practice response to questions of autonomy and accountability.

The **fourth** content area on the second square of the surface of the quilt is an exploration of the changing responses made by individuals and the profession. The remarkable changes included moving from a time when the student nurse was certainly not autonomous, and had as one of her main areas of 'professional responsibility' to be courteous to senior staff, through to debates about professional accountability and autonomy within the profession.

Prior to the 1980s, when nursing care in hospitals was provided predominantly by students, the question of 'practice autonomy' and accountability was not a major concern for the profession in New Zealand. The students were said to be working under supervision and the Registered Nurse in the ward or unit was responsible for the decisions made relating to patient care. The legal accountability for responsibilities specified in job descriptions or lists of duties were influenced in large part by the extent of an individual person's authority or power to make decisions – and indeed their willingness to do so. Many Registered Nurses considered that they were usually acting under Doctors orders (and indeed so did the doctors).

McGann (1995), writing about the development of accountability in nursing in the United Kingdom, proposes that

the hierarchical organisation of nursing in hospitals produced a hierarchy of accountability, which detracted from the accountability of the nurse at the lowest level. Without legal status, without professional autonomy, and with a system of training which undermined professional confidence, it was unlikely that nurses...would develop that professional *esprit de corps* which was necessary to foster professional accountability.

(McGann, 1995, p.29)

Logically it was not until the late 1970s and early 1980s in New Zealand, when major changes in nursing education were followed by necessary changes in clinical practice, that the question of autonomy for the nurse began to be an issue and to be written about and debated in New Zealand (Chappell, 1984; Laws, 1984; Shaw, 1980).

As the transfer of nursing education began to impact in the 1980s, and when the focus of nursing returned to be more patient centred, and aimed at meeting patients needs, there was an increased opportunity for autonomy in the sense of capacity/freedom to choose, freedom to act, for both the nurse and the patient, and subsequent increased accountability. The authority to act for the nurse was often detailed in individual job descriptions along with associated expected outcomes for which they were responsible.

Questions of autonomy and accountability related to clinical practice in New Zealand became increasingly important to the profession, the individual nurse, the employer, and to the registering body – the Nursing Council. Over the past three decades, NZNA, representing the profession, developed standards of service, education, and practice to assist clarify the impact of responsibility and accountability. NZNA developed a series of

policy statements including a statement of social policy underpinning the accountability of the profession to the public and revision of a code of ethics all assisted in the self-regulation of the profession. The individual nurse adapted modes of practice to enable her to practice in more autonomous ways, and participated in the development of clinical career pathways and developed portfolios of work alongside taking responsibility for her individual continuing education. The employer developed job descriptions detailing expected outcomes, practice protocols, and became more aware of their own accountability to ensure every nurse had an up to date APC. The Nursing Council developed standards and audit tools for schools of nursing, and published codes of conduct and guidelines for competency based APCs as well as information about the disciplinary functions of the Council.

Margaret Bazley illustrated an individual ongoing commitment and continuing contribution to the accountability and autonomy of the profession. Having seen the transfer of nursing education off to a successful start while she was President of NZNA, she then moved to support the development of nursing services to meet the future needs of the comprehensive graduate as part of the ongoing forward push in the 1970s to match developments in nursing education with developments in clinical practice. In 1975, in her position as Deputy Matron in Chief of the Auckland Hospital Board she spoke at a national seminar “Focus on Nursing’ discussing the work and findings of those who were part of the committee preparing the 1974 report *‘An improved system of nursing services in New Zealand’*. She was a participant on that committee, and was keen to build on the theoretical ideas associated with patient centred nursing.

We need a system whereby nurses are responsible and accountable for their area of work. They will be educated to function in this way in the future and we must provide the opportunities for this to

happen. Most important of all I hope that we will gain a more personalised system of patient care, that patients will have their nurses. That they will receive continuity of care, that the nurse will be free to devote her time to her patients. From such a reorganisation I visualise the type of nursing being given to all people that I would like for myself and my family.

(Bazley, 1975, p. 15)

In her next position as Chief Nurse in the Ministry of Health, she continued to support and encourage the profession to develop its potential.

As outlined in the context chapter, career development for nurses in New Zealand until the 1980s was predominantly in the education or administration stream. Nurses left clinical practice if they wanted to enhance their careers. This had a major impact on delaying the development of autonomy and accountability for the nurse in New Zealand. However, once new modes of clinical practice began to evolve and the R.N became the predominant caregiver, issues of autonomy and accountability built on decision-making ability began to impact.

Internationally and nationally nurse academics promoted these new modes of practice. Team nursing, patient assignment, and primary nursing modes of practice all required decision-making by the nurse and a degree of autonomy and accountability.

Kelly and Joel (1996), American academics, suggest that 'practice autonomy' was the key to autonomy as applied to nursing, as no other professional or administrative force can control nursing. It was the nurse who is free to act and make judgements about patient care **within the**

scope of nursing practice as defined by the profession [my emphasis].

On the other hand, if one accepts the idea that any activity that provides a nurse with the opportunity to ‘nurse’, to interact with the patient, then the extension of the nurse’s role into management and high tech areas is a plus for the patient.

In the 1970s and 1980s the debate associated with deciding the scope of practice of the nurse, the place of an extended or expanded role was addressed both internationally and in New Zealand as a challenge, a tension (ICN, 1997; Nursing Council, 1999; NZNA, 1984; Styles, 1986). This tension still exists with Hildegard Peplau, recipient of the prestigious Christianne Reimann prize saying in her acceptance speech at ICN in Vancouver in 1997 “Nurses have to move away from discussing what nurses do - and discuss what nurses know, and how they use that knowledge to benefit people”(personal communication).

As I reflect more about our angst in spending energy describing ‘what is nursing’, rather than focusing on the diversity of opportunities to contribute our skills and expertise, the more evidence I find for shifting focus to consideration of health outcomes and contributions of the competent professional nurse. (Bruni, 1991; Clay, 1987; Cox, 1993; Shaw, 1980; Nursing Council, 1995; Peach, 1992). Lee Mathias believes strongly that nurses need to look carefully at what they choose to do or not do in the name of ‘nursing’ – reluctance to carry out activities perceived as ‘non-nursing’ could mean that nurses lose opportunities to interact with patients –lose opportunities ‘to nurse’. Once again we are drawn to the question – What is, and who defines the scope of practice for the nurse? Answers to this question may be found in considering the ‘struggles’ in the exercise of power, and the mode(s) of clinical practice we choose.

It is interesting to look back in history prior to the 1960s to the time when the nurse worked autonomously, predominantly in the patient's home providing total patient care and enjoying a close relationship with her patient. Saunders, an American nurse, writing in 1954 provides a statement relating to the changes in the previous 50 years or so where the nurse changed from a self employed entrepreneur to a salaried employee. She described the nurse changing

from a person who worked largely alone and self directed, to one who shares in a minute and highly specialised division of labour; from one whose relationships with those she worked among were close, intimate and personal to one whose working relationships with both patients and colleagues, are subject to strong pressures toward becoming both impersonal and segmental; from one whose skills and functions were generalised to one whose skills and functions are very highly specialised.

(Saunders, 1954, p. 1096)

This picture of a self employed entrepreneur in the early part of the twentieth century certainly applied to the New Zealand context as reported in the NERF oral history tapes and the records of the *NZNJ* over time.

In discussing how nursing dependence evolved McCloskey (1981), commented that writers often suggest that the factors involved relate to the basic issue of 'power'. Embedded within a hierarchy of authority of 'others', dependence on the orders and policies of these others led to a feeling of powerlessness. The visible and obvious power previously displayed by independent nurse practitioners disappeared as care moved from people's homes into hospital facilities. The impact on the profession as a whole and on the individual nurse led to loss of the sense of

autonomy needed by a maturing profession and to an increasing sense of dependence and associated powerlessness.

This sense of a feeling of powerlessness has been referred to often by New Zealand nurse writers (Benjamin & Mullard, 1987; Bickley, 1984; Instone & Stevenson, 1987; Moulson, 1984; Shadbolt, 1986), and over time led to a mentality of ‘followship’ – follow the leader, rather than developing a pattern of leading. This is an interesting attitude to explore further, particularly in relation to the profession in recent times with the loss of positions that provided that ‘positional authority’.

When considering the relative freedom currently permitted by the New Zealand Nurses Act (1977) with no defined boundaries limiting the scope of practice of, or for, a nurse, the comments earlier in this chapter about those nurses in ‘positional power’ failing to use the power at their disposal is interesting. Were we, or indeed are we, as a profession really powerless? This is well argued by two New Zealand nurses in their paper *‘Petrified in the power pyramid’* and includes the following comment, “Nurses have always had power – the problem is the way in which it has been used-abused-misused-and disused” (Benjamin & Mullard, 1987, p.1).

I cannot count the many times have I read about and been engaged by others in conversation considering the potential power of nurses and nursing, both internationally and within New Zealand, especially its ‘disuse’ (Benjamin & Mullard, 1987; Millar, 1980; Muff, 1982; Powell, 1987; Salvage, 1985). At the highest level internationally – at WHO and ICN this potential is described and the profession as well as individuals encouraged to take up the challenge of demonstrating this potential, the difference that nurses can make (Harlem Brundtland, 1999; Mahler, 1985; Styles, 1997). Some of these ideas and opinions linked to power addressed ideas of the professions struggle to be free of control by others, the

necessary political growth of the profession, the wasted opportunities, and the resistance and even alarm expressed by other health professionals as they saw the possibility of their own power diminishing. While individual nurses may have worked through the power/powerless dichotomy, the nursing profession as a whole still needs to gain more clarity about the question – are we (the profession) really powerless?

Dunkley, Deputy Executive Director of the ANA in 1975, stated that nursing had worked long and hard to achieve some level of control over its own practice, struggled to be free of control exerted by hospital administrators and physicians: and to carve out and demonstrate a health care role that was broader than management of the environment, doing treatment and medicines.

Mia Carroll commenting on this struggle suggests that this search for control could have been associated with the political growth of nursing, and that maybe we could have handled situations differently.

I think we had to shift from a subservient role but we stuck our hands up and battered people with our autonomy. I don't know whether it is age or whatever but I now see that that was necessary – much like women needing to strike independence but now I'm a little older and I hope wiser and recognise that it just simply doesn't help to be doing it that way.

(Carroll, 2:5)

Ford and Walsh (1994) propose an interesting theory that subordinate groups (nurses in this instance) actively but unknowingly participate in their own subordination. They support this argument by proposing that this can occur when nurses extend their role. In areas where there is a high use of technology they fulfil doctors' orders, and thus become subordinate to medicine. Similarly when nurses move into management roles they are

subordinate to management as they pick up budget and resource management tasks.

If one accepts this argument of subordination, then the increasing autonomy and accountability associated with patient care (practice autonomy) becomes all the more significant for the nurse, as does the prophetic comment of Etzioni (1969) a sociologist who wrote prolifically about the health professionals in the 1960s. He suggested that the best prospects for autonomy for the nurse might be a return to the bedside. However, if as Chalmers (1995) proposes, the replacement of the knowledgeable doer with the knowledgeable supervisor becomes a reality in the health restructuring, leading to an unqualified cost effective workforce, accountability could again be rendered remote from the delivery of care.

The struggles related to practice autonomy have been linked to the concept of power, and historically world-wide the nurse moved from a position of independence to dependence. Dependence on others authority – the medical profession and the bureaucracy. This dependence resulted in the profession perceptions or belief in a sense of powerlessness. The question we are still struggling with today is – are we really powerless? Are the international leaders who keep talking about the potential value of the nursing profession wrong? Do the recent developments relating to extending our role mean we participate in our own subordination, or is the question really one of the disuse of power? Have we really ‘lost’ power or are we confused about power and authority. As outlined in the earlier section exploring the term ‘authority’ associated with the loss of power we need to find new ways to influence and to create structures that allow the exercise of professional autonomy. A warning note is raised regarding practice autonomy – perhaps the professions best prospect for such autonomy is at the bedside – so we need to be cautious as clinicians about

the risk of becoming the knowledgeable supervisor rather than remaining the knowledgeable doer.

The mode(s) of clinical practice we use also help define accountabilities associated with our scope of practice. With the move to patient allocation and primary nursing, nurses began to realise that increased authority and responsibility, accountability for their actions rested with the individual nurse, regardless of whether or not their actions were derived from the instructions of others.

The nursing process and accountability share a common concern of encouraging nurses to be more conscious of the decisions they take, more aware of the care options that are available, more willing to document the decisions made and the rationales for them and more self questioning about the success or otherwise of action taken or omitted.

(Chalmers, 1995, p.34).

Team nursing has been criticised as lacking accountability because of the shared responsibility of the nurses within the team. Manthey (1992) an American nurse leader in the development of the concept of primary care nursing, suggested that such shared responsibility (associated with team nursing) equalled no responsibility, but that it was primary nursing that provided the opportunity for a marked increase in the accountability of the individual nurse. In support Evans (1993) suggested that primary nursing makes the issue of accountability more clear for the nurse. It allows the nurse to take the concept of accountability and be proactive with it, grasping it with enthusiasm. The primary nurse is the one who makes the decisions about the plan of care for their 'primary' patients, they take the responsibility for the plans and therefore the accountability for the plan of patient care. Manthey (1992) suggests that primary nursing provides ways that the nurse can give professional care and have autonomy and

accountability for that care within a bureaucratic structure. In support, UK writers Goulding and Hunt (1991) suggested that the three concepts of responsibility, authority, and autonomy are well defined in primary nursing.

In New Zealand in the 1970s both the hospital-based nursing schools and the Technical institute schools began to place the patient at the centre of care, and the question of the role of the individual health practitioner was debated in earnest. The tension created during this period, however, was the question of the theory practice link. How much did the nurse teachers of the day encourage an understanding of clinical practice tools - nursing assessment, nursing history tools, and patient care plans - when the reality of practice denied application? Why would you learn about how to take a nursing history, or write a care plan, when these processes were not used in clinical practice? This situation was especially common in the hospital schools of nursing. I recall discussing this tension with students often emphasising the need to be aware of trends and developments in one's own discipline, the discipline of nursing. I was clear in my own mind that the changes in nursing education would inevitably impact on practice and the profession needed to be ready. The question for the learner however was what to do with the knowledge if you couldn't use it – 'use it or lose it.' It was probably not until the state examinations leading to registration as a nurse included questions relating to these new modes of practice that students began to develop real understanding of the ideas. While primary nursing pilot schemes and trials of nursing histories and patient assessments were evident in some areas. The reality for many nurses was a continuation of task or functional nursing well into the 1980s.

Sally Shaw in her position as Assistant Director (community health nursing) in the Division of Nursing of the Department of Health, commented on the importance of the individual AND the team as the tension of the influence of the context of teamwork on autonomy and

accountability began to emerge. This was long before the majority of nurses were ready to give up their newly recognised fledgling 'autonomy' and reconsider the role of teamwork and the nurses' place within the team. Shaw (1980, p.41) asked the question "how does an individual become part of a team and how does a team become an effective unit?" She suggested that "individual goals and team goals must be reconciled if we are to achieve autonomy without isolation while working together in our various areas to achieve better health care" (Shaw 1980, p.43). Autonomy without isolation was to become an important concern in the 1990s as outlined in Mia Carroll's vignette at the end of the chapter.

Throughout Sally Shaw's career, in the Department of health, as the CEO of Eastbay health, and as a nurse consultant with ICN, the concept and influence of team and associated concepts of partnership and collaboration have been important to Sally, and promoted to the profession. An era of major contribution for Sally was in the late 1980s with the introduction of general management in the health sector, when pressure began to be placed on senior nursing positions. Sally reflected on the values and needs of this difficult time as perceived by some of her Chief Nurse colleagues. She describes a meeting (which I attended as Executive Director of NZNA) where she discussed the major changes brought about by the introduction of the concept of 'general management' into the state sector, and how this would be likely to impact on nurse leaders.

*Well there were one or two people there – I mean as you know – there were a lot of people there who said it will never change. It [general management] will never come, and there were those who said – there were a few – in fact **two** who said if it does ‘I’m going to try and go with it. There was a large group that said well they’d go with the flow really, but they weren’t going to be active...because they were all so nervous and fearful of changes and what it would mean for them, and there were one or two who just said ‘I’ll resign’ and they did.*

(Shaw, 2:7)

During the major restructuring especially into ‘service management’, some of the ‘nurse clinicians’ and ‘nurse consultants’ transferred into management positions while others who wished to stay in clinical practice found their positions disestablished and surplus to requirements. While in principle this should have enabled the Registered Nurse to let go the dependency on the nursing hierarchy and to develop increasing personal autonomy, in practice many staff nurses had not taken the time to develop the self confidence required, and floundered with the lack of mentoring and supervision – they did not have either ‘expert’ or ‘situational’ authority.

Increased pressure on the staff brought about by ever-increasing change in the health sector from the late 1980s meant that experienced nurses left through dissatisfaction and disillusionment. Some of the participants believed that in some areas the profession lost a generation of experienced staff which put back several years the development of an autonomous nursing workforce (Lee, Mathias, Peach, Shadbolt).

When asked to take on additional responsibilities nurses needed to ensure that they were adequately prepared to undertake those responsibilities as performance brought with it accountability for the action taken. This was

especially important for casual/relieving staff who were required to work competently in a variety of settings. This was not always appreciated or recognised by those in administration of nursing services, and individual nurses could find themselves in a dilemma when asked to work in an area in which they did not regard themselves as competent. My personal experience in this area includes new graduates being asked to work in intensive care units where they have never been before; new graduates being left 'in charge' of a unit within weeks of graduating as an R.N; competent practitioners in specialities such as care of older persons being placed in acute mental health assessment areas. A developed sense of individual accountability and acceptance of responsibility for ones actions is a prerequisite to safe decision-making in accepting patient care assignments in these situations.

As individuals struggling with concepts involving the right to self-determination; and 'practice autonomy', we needed to consider our role within the wider team and how indeed we could achieve 'autonomy without isolation' and ensure that the patient in the end is the prime beneficiary of our decision-making.

Growing recognition of the need to increase their knowledge of the discipline of nursing meant that many nurses in the 1980s took the opportunity to update their qualifications. By the mid 1990s a critical mass of nursing staff was being developed with more confidence in the knowledge needed to underpin their clinical practice skills, as well as in their ability to function autonomously in those matters related to their practice.

This developing confidence means that one of the requirements for autonomy previously mentioned i.e. the individual professionals' willingness to *exercise* autonomy may soon be realised. Whether the

second requirement, the organisational structures willingness to *allow the exercise* of freedom to act, will be met is not yet so clear.

While some managers are quite clear that nurses have sufficient autonomy with regard to their decision-making related to clinical practice, many nurses disagree, perceiving the lack of nursing control over nursing staff numbers in a particular unit, to meet patients needs for nursing, is not freedom to act. For example in 1993 in a busy orthopaedic unit, in a large metropolitan hospital, five new emergency admissions put enormous pressure on the nursing staff. A request was made for more staff but management refused because of budget over runs (personal experience). Clearly the organisation structures willingness to allow freedom to act did not exist in this instance. Similar stories are still being reported in 1999.

Catalico, Navas, Sommer and Collins (1996) define the *quality* of decision-making as having both ability and willingness. Willingness in this instance relating to the likelihood of the R.N to make decisions they believe should be made. This could include decisions that may or may not be in the province of nursing, but impact on the patient and/or their family.

Autonomy builds on quality decision-making - decision-making that is crisp, timely, and stands up to scrutiny. Do New Zealand nurses in the 1990s make quality decisions? Have they the ability and willingness so to do? I am not sure on either count that the answer is an unequivocal 'yes'. Evidence from personal observation, anecdote, comment from colleagues and most of all the participants in this study would suggest that in some areas (particularly where advanced clinical decision-making is required) some nurses lack confidence in their own ability (lack expert authority) and consequently are unwilling or unable to move forward. The question is are there enough New Zealand nurses willing and able to make the quality decisions that autonomy and accountability could build on?

The oral history participants provided a challenging and thought provoking insight into their world, as they gave time and energy to the development of the profession over this period. They shared their ideas, and provided role models for the next generation to consider, particularly the desirability of reflecting and debating the meaning of autonomy and accountability to the profession as a whole. The need for self – belief and confidence was quite explicit and should see the nurse free to take her place at the policy and planning table, and able to articulate the value of both the nursing profession and individual nurses to the health of the peoples of New Zealand.

In the next section, two participant vignettes enabled me to consider the two key concepts at a greater depth. They enabled me to pull together many of the ideas, the experiences, and the maturation over time, to reconstruct how it must have been particularly during the tumultuous 1970s - the changes in nursing education, clinical practice, nursing regulation, and then on top of that – a professional debate about autonomy and accountability, that is still underway.

Mia Carroll's vignette explored the concept of autonomy, outlined her journey, her experiences and her reflections on the difficulty many nurses have with the concept. For me this was a valuable opportunity to rethink my own ideas and develop a new awareness of my responsibilities regarding professional autonomy.

Marie Burgess had quite a different approach emphasising the idea of professional accountability, and the statutory obligations that she felt nurses needed to consider in more depth.

Participant Vignettes.

I chose the two very different participant vignettes to provide a slice in time, a more in depth look at the development of the personal beliefs,

attitudes and practices of two of the participants to enhance and develop this theme of 'an emerging understanding of autonomy and accountability'. Both Marie Burgess and Mia Carroll were very clear about the importance of nurses taking responsibility for their actions and being accountable, while Mia added another dimension in a broad ranging exploration of the term autonomy.

The differences in the two vignettes demonstrate how as we mature and develop our careers, the impact of the experiences gained, influence our attitudes and beliefs, and in a cyclical way, the changing attitudes and beliefs then influence our responses. The interpretive framework developed to construct this account has been very useful in gaining an understanding of the context, exploring the source material, and by sifting the sources through the series of four contrasts developing more complete researcher understanding. The methodological principle that there is always the possibility of new information or new understandings has been well illustrated in the exploration of an emerging sense of autonomy and accountability.

Vignette one: (Mia Carroll).

This vignette focuses on the question of autonomy. Mia used her experiences as skilled nurse practitioner in the ICU setting, a feminist, an inservice educator, a nurse teacher, a leader in the 'nurses are worth more campaign, an experienced nurse administrator and a questioning student, to focus on her concerns for the profession as a whole. She also explored the question of how we interpret 'nurse autonomy' (if such a thing exists) when health professionals in general are working towards the practice of partnership and collegiality with the patient as the focus.

Mia registered as a nurse in 1974 and went overseas working in Intensive care and renal dialysis units. A choice emphasising the opportunity she felt was provided in caring for people on a 1:1 basis. In the late 1970s

having returned to New Zealand, travelled again, taught in a post registration Cardio-thoracic course, and completed her psychiatric programme in Canada, Mia worked in ICU at Greenlane Hospital and moved into inservice education in 1980. Staff development and inservice education requirements were in high demand at this time preparing R.Ns to provide care in new ways.

After completing an Advanced Diploma of Nursing in 1983 and being put on permanent night duty on her return to practice, Mia applied for a position at the newly commissioned North Shore hospital. She then spent 'the two happiest years of [her] life' as a charge nurse manager in a general ward. Attracted back to teaching, Mia worked for 7 years teaching in the comprehensive nursing programme and after a period working part-time in clinical practice, she was appointed Nurse advisor at Auckland hospital. She is currently Director of Nursing and Midwifery for Auckland Health care. Mia began studying for a Bachelor degree when she was a nursing student completing this during her time as a nurse educator. She is currently studying for a Masters in public health.

Mia is passionate about nursing and the need for strong leaders within the profession.

Common patterns in relation to autonomy and accountability mentioned by the other participants included the importance of nurses recognising they were individually accountable for their choices and not doctors' handmaidens, confidence as a pre-requisite to autonomous accountable practice, and accountability and the concept of authority.

Mia described her experience in the mid 1970s while working in ICU in the United Kingdom. She described a 'doctor/nurse relationship' of a kind that she had never encountered before, and that certainly did not represent a collegial relationship as she knew it.

I learned in ICU about some of the worst kind of relationship between physicians and nursing staff. We had a physician in the unit I worked in which I shan't name who used to 'dial a nurse for supper'. I'd never encountered that kind of unprofessional behaviour before. What staggered me even more were the willing applicants that he used to have when he dialled for supper. Of course those of us who were 'colonial' were far more stropky than that and far more lacking in subservience and so the relationships that we very quickly established with British medical colleagues...were collegial and not subservient [relationships]. But we did so because we didn't give a toss what they thought of us and we were also very secure. I was very secure in my clinical knowledge and there were things – no thank you, I don't do that for you, you can do that for yourself. Right from the earliest stance I only worked for the ANZAC agency ... we were good clinically so we were highly employable. I was never short of a job.

(Carroll, 1:7)

Working overseas, the New Zealand nurse in the 1960s and 1970s had a good reputation, and many New Zealand nurses felt competent to practice internationally (personal experience). Mia also had worked in a New Zealand unit with an international reputation for high standards.

I also learned that I came from a unit that had a lot to offer the world...I felt proud. Proud of the standards of nursing...I was left with a secure feeling that I can do this, I know what I'm doing, I'm comfortable about learning really.

(Carroll, 1:2)

The importance of confidence was a concept many of the participants raised and explored over and over again. Mia talked about the time in then 1980s when she was in inservice education and was running 'assertion

workshops', a feature of the 1970s and 1980s when we were seeking to increase the confidence of the R.N to cope with being the dominant carer.

It was a real privilege. I mean teaching nurses how to say how they feel and set limits and ask for what they want was an extraordinary time...It was around being women, nurses, nursing relationships and communicating...The big thing was (and I loved throwing it in for debate) we used to have great conversations about peoples distress about putting a uniform on and being expected to assume huge responsibilities in clinical practice and then going home to serve subserviently in a family setting.

(Carroll, 1:8)

We also discussed accountability and the concept of authority, especially when you are in a position where you have the authority that is associated with a leadership role, (positional power). Mia described her consideration of the authority of her leadership role over the past year, as Director of Nursing, and her disaffection with 'power over' acknowledging the dangers associated with such an attitude.

You can become full of your own importance and become the position instead of the person and so – getting comfortable with both the accountability of my position and the authority of my position was part of my growing up this year. And I think being accountable for decisions that go wrong – is really - you've got to have a sense of self and not feel like you are your position to be able to do that. That's tricky I think – I don't know whether it comes from maturity or not but I think it can be helped if we learn from the things that have happened.

(Carroll, 2:12)

The concept of autonomy is an idea that has changed for Mia as she has explored, debated, and reassessed what the term meant for her in the light of her experience particularly in her current role as Director of Nursing. She had included critical examination of the term 'autonomy' during academic work with Professor David Seedhouse and a critical exploration of the term autonomy. Mia described the basis of his ethical model in relation to autonomy as that life is about either creating or respecting autonomy. Creating more capacity for people to make good choices or respecting their current choices and this applies to nursing as either creating or respecting somebody's autonomy.

I did a major critique on autonomy as part of an ethical paper and I think that autonomy as 'a capacity to choose' is a wonderful concept. I think autonomy, as 'a way of acting solely independently' is a noxious concept that would potentially lead nursing down a path of vulnerability and terror for many practitioners.

(Carroll, 2:4)

Speaking to the notion of creating or respecting autonomy, Mia explained how she applied this each day.

I love that notion - when I've defined that for myself, as I am either in the business of creating more capacity for people to make good choices, or respecting their current choices. I cannot see – and I ask this often of the nursing staff, I cannot see an opportunity or an occasion - if it's fixing a fractured neck of femur, or someone dressing a wound or curarizing them so they can recover from a head injury, or committing them so that they can choose not to kill themselves – I think our constant process of nursing is either creating or respecting somebody's autonomy...It fits very comfortably and then for my analysis I can ask myself the question – What am I doing here? When do I flip between creating and/or respecting autonomy and is my need to restrain here about creating autonomy or is it respecting autonomy and if I am 'dwarfing somebody (which is what he describes as when we don't give them that choice) then have I the justification to do so? – It's a lovely – it's a very easy tool. I use it in my day about how to allocate my time so it's – am I creating space for nursing practice to occur or not and if not why not.

(Carroll, 2:9)

Mia then built on the idea of autonomy as a way to act and choose with the patient as the focus expressing the belief that such an approach is strengthened by collaboration.

If autonomy is a way to act and choose in a way that is professionally either valid or good for clients and promotes whatever outcomes you want, then it's great – yes I want that.

I want the capacity to choose, and what influences that for me is the stuff of my knowledge, my academic preparation, my skills in life, my ability – meaning intellectually, economically and everything else. I think that autonomy as capacity to choose is strengthened by collaboration – so that’s where I am at with the concept. I’ve stopped promoting nurses as autonomous practitioners. I think what I now discuss with nursing staff is that there is a level of capacity to choose differently but it is always in collaboration with others – partners of clients, partners of families, partners of every other discipline that’s around.

(Carroll, 2:5)

This idea of collaborative practice has become increasingly significant in the late 1990s, as outlined earlier in the chapter, and several other participants were also re-examining the interpretation of the concept of autonomy as we move more to consider health teams, and partnership models.

While Mia agreed that there are some decisions she makes autonomously and will be accountable for, she does not think that the profession of nursing is autonomous, as nursing is a “*highly collaborative endeavour*”. The importance of confidence for the individual nurse and collaboration for best outcomes for clients was discussed leading to elaboration on the meaning of autonomy for her.

I think that the confidence I get through having affirmed successful decision making allows me to take more risk – to function slightly more independently before I seek either advice or collaboration but that’s really all it does. I think it is confidence that allows me to summatively bring together all the evidence...

When it's recognised as being a valid perspective, and/or is affirmed in some way then of course that leads you to believe you can put that forward more.

(Carroll, 2:4)

The concept of collaborative partnership was explored as an option to 'replace' for want of a better word, autonomy. Mia elaborated more on her understanding of partnership especially the idea of 'equality' in a partnership – linked to some of the ideas of 'power' explored in the theme chapter.

I think partnership has been a concept that I've liked, lived – well we all live it. The quality of partnership is...a bit of a life goal really. I mean it's both in my home relationships and my relationships at work. One of the things I've discovered recently and we've debated as part of the senior nursing team is that partnerships are not always equal, and you can still have one. The bizarre thing is that I think through either fixed beliefs about equality or you know struggles of where society and women have been placed in New Zealand, we've argued partnerships are equal – equal equal. Now I think I'm comfortable with the fact that...partnerships don't need to be equal. Sometimes I'm much more vulnerable than [my partner] and sometimes [my partner] is much more vulnerable than me and that is what makes the partnership. It's that capacity to be vulnerable and I think that when you see vulnerability as a strength it shifts the power base ... You can strive to make them [partnerships] more equal and it comes back again to creating or respecting autonomy.

(Carroll, 2:10)

Mia discussed negotiation within a partnership model and a brief definition that the senior nursing staff where she works has developed

around partnership, looking again at the issues of power and empowering.

I'm not sure if I can remember this off the top of my head, but I think that what we said was that 'Partnership is best enabled by collaboration, co-operation, and direct, honest, open and skilled communication'. That's the premise and/or the value on which we are embarking knowingly on equal or unequal relationships and I think that it is that partnership where you need insight into your motivation and your way of being. Not everyone wants to share power and partnership with clients sometimes – I mean the whole partnership concept requires that you look really carefully at what you do that empowers versus dis-empowers and if you're not willing [to empower], to look, reflect, examine...I guess the partnership is around creating non-victim participation in the partnership and if I operate like that I think I am creating autonomy and so if you like – it is partnership.

(Carroll, 2:11 –12)

How did Mia assist others develop a sense of autonomy and accountability.

Acknowledging that Mia had already described how through questions and debate she assisted others to explore the meaning and implications associated with autonomy as a concept, and her own use of the 'Seedhouse model', I asked Mia if there were any other ways she used to assist others to develop a sense of autonomy and accountability?

In her role as a nurse leader Mia often took the opportunity to speak with nursing students at the local Polytechnic. She shared a recent experience where she explored with year three students the need for supporting the new graduates and giving them permission not to know enough –not to be 100% sure

*“I’ve just come from talking with a gorgeous group of unit six students at AIT and I had gone to talk with them about leadership and I humbly put forward to them that I didn’t believe that they were autonomous practitioners and in fact if they came and worked with us they won’t be. I talked with them about my dilemma of in the past us [the nursing profession] believing that they would be out there functioning as comprehensive nurses and knowing full well that when they came out and they haven’t done a task before, there is no way they engage with a client. They need time to comprehensively get confident with assessment and skills before they engage, so I said my vision at the moment is that I probably will reduce your autonomy – hopefully not in a dictatorial or unreasoned way but to give you the confidence so you will grow in skill. There wasn’t one among them who said ‘No Mia, we want more’ and I think we haven’t yet given them permission **not** to know enough.*

(Carroll, 2:6)

The idea of nurses – especially the young new graduates being given permission to NOT know enough is attractive to me especially when we are seeking ways to provide sufficient staff in times of shortages of experienced staff. The importance of preceptors and an effective orientation programme have been with us a long time and yet we still leave nurses in positions of vulnerability.

As previously stated by Chalmers (1995), the importance of a supportive environment enhances the development of autonomy and accountability. The development of a culture that supported the ability to share ideas, to seek advice, to gain affirmation of others was very important to Mia. She believes that there has been little acknowledgement that it takes time to learn, and interpret cues in a multitude of ways, and that diagnosis is a whole land of uncertainty. Uncertainty can be lessened by discussion with

people who have more experience, more wisdom, more grasp of the literature on that occasion. She was concerned at the nature of how we create supervision, and that the lack of peer review could also lead to a de-skilling of the workforce. The lack of willingness to share their vulnerability could lead to the idea of 'autonomy in isolation' as discussed by Shaw (1980).

We have a lot of [nurse] practitioners out there who are not confident in their diagnostic skills and they hide therefore in a vehement sort of way. 'I know what I am doing', but if we allowed permission to say I'm not 100% sure of what I am doing – this is what I think – and that was more the norm then they'd grow in confidence as collegially that thinking was confirmed as being – yeah pretty good. 'I agree with you and so does the Reg. (Registrar) and so does the consultant'...I think primary nursing has been interpreted by some as 'I'm in charge, don't think you can muck about with this client of mine' to their detriment sometimes. What this loses is the great diversity of nursing and the great difference that somebody else's brain can bring to a discussion – so I think it's resulted in isolationist practice and a de-skilling of the workforce because there has been no supervision.

(Carroll, 2:6)

The attitude of some staffnurses doesn't help when they fail to see the collaborative value of supervision and preceptorship, and fail to contribute positively to the environment. This has been an increasingly problematic area over the last decade when pressures on the fulltime staff have increased impacting on their ability to work competently. We need to remind nurses that we work collaboratively, that supporting and guiding those less experienced than us is part of professional responsibilities. Mia has been concerned at the number of staff who believe that supporting others is a burden.

I'm staggered by the staff nurse perception that they are doing somebody a favour when they precept them. They've still not learned the art of facilitating student experience and seeing it as a bonus instead of a drain. A lot of coaching that I do with preceptor workshops with new starts, new grads, whatever, is around this stuff and it's around that relationship of reciprocity, and recognising it as so, and it's around you're not doing anyone a favour – this is your job for goodness sake. And we've rewritten some accountability into the staffnurses job description that asks for contribution to positively in the environment. I'm tired of "Well Poisoners" (staff nurses who do nothing but moan and whinge and express their negativity left right and centre, and deluge a ward full of bright enthusiastic willing people). But they can never rise above this well poisoning actively. I mean we have this philosophy and saying...You can visit 'pity city' but you're not allowed to stay there. It's time to move out. You can feel sorry for yourself and you can ask for support and hopefully you can get clear communication but some of the stuff – we've got to stop.

(Carroll, 1:18 – 19)

A victim mentality is a real barrier to the concept of the primacy of the nurse. If we are not able to move forward and make progress as a profession, our future will be at risk

Mia's experience in clinical practice, and her willingness to maintain her own skills, has raised for her the possibility that the lack of supervision provided for inexperienced staff impacts on their attitude to peer review, and a 'tenuous grasp on client care'.

There has been no acknowledgement that it takes time to learn and interpret cues in multiple ways, and that diagnosis is a whole land of uncertainty.

That uncertainty is made more sure by discussion with people who have more experience, more wisdom, more grasp of the literature than you might possible have. So I think this notion of autonomy has even meant that 'I won't necessarily invite you to review my practice' I mean that for me is a sadness that we don't have good peer review because we're such autonomous practitioners that who would have the right to challenge what I am doing and what – I think it has built a very tenuous clay footed grasp on client care really.

(Carroll, 2:6 – 7)

The notion of autonomy as independence in practice can lead to this 'very clay footed grasp on patient care' because who then has the right to challenge. Mia wanted to change that and create an environment where nurses will challenge each other based on evidence – and where there will be increased tolerance for multidisciplinary collaboration. The concept that 'this is my area of knowledge' where the nurse believes she 'knows' has led to a strengthening of turf disputes rather than weakening them. To address this difficulty Mia has embarked on bringing in a process of group peer review for the senior nursing staff, and strengthening the peer review process in the appraisal system

At the moment we are very light weight in critiquing each others practice – we tend to tell the nice stories but not 'When I see you do something that I think is not so good'...or 'tell me why you did that'. Even that is a very frightening question for people they seem to find that an 'affront' these days instead of the norm...We have a culture that doesn't view investigation or asking those questions as the norm.

(Carroll, 2:6-7)

This leads us back to the question of accountability – how can we say we are accountable when we don't encourage critique of our practice?

I think there are very few people who are truly prepared to be accountable for their decisions and for their actions and for their interventions, and we are not breeding a climate where we make it easier for them.

(Carroll, 2.12)

How we create a climate or culture that does encourage challenge as well as provide support, and that promotes a competent confident practitioner willing to work in a collaborative way is our challenge.

This first vignette has focused on the concept of autonomy. It provides an insight into a developing understanding and interpretation of what autonomy means to Mia as a result of considerable thought and reflection.

Acknowledging a maturing of ideas, again particular events acted as triggers to enable Mia to move forward. A critical examination of autonomy from a philosophical viewpoint led to taking and applying in life generally the idea of 'creating or respecting' autonomy along with the capacity to choose.

Vignette Two. (Marie Burgess)

This vignette focuses on accountability. Marie used her experiences as an independently functioning community nurse, an educator, an activist in NZNA, a nurse historian and a nurse adviser for the Nursing Council, to clearly build on the need for effective decision-making and emphasised the importance of accountability for both the individual and the profession.

Marie registered as a nurse in 1966 and her experience with a public health nurse as a student impressed Marie greatly and began an interest in

public health that was to continue for the rest of her career. After registration, Marie went overseas and did some District nursing in the Shetland Islands and then worked in Canada. On return home she began work as a public health nurse and the next year (1971) went to SANS to complete a diploma in public health nursing. At this time public health nurses were at the forefront of nursing with Principal Public Health Nurses a strong group taking leadership roles in the community, and within the Department of Health where there was a strong public health focus. This SANS experience was very influential. 'The scales dropped from [her] eyes' and she felt she was exposed to teachers who were way ahead of other thinkers at the time in New Zealand (Bea Salmon, and Alice Fieldhouse).

Midwifery followed – a huge culture shock back in a hospital – wearing uniform, and treated as if you knew nothing – shown how to give injections and bath a baby – by an enrolled nurse. In 1974 Marie moved into a teaching position teaching community health nursing in the new comprehensive programme. She continued to teach in both the comprehensive and the Advanced Diploma programmes during which time she completed a Bachelor degree in nursing.

In 1983 Marie sought a career change, as she wanted to do some writing. She worked part-time while she wrote her first book '*Nursing in New Zealand Society*'. In 1986 she began work with the Nursing Council as Nurse Adviser (Investigations) dealing with complaints relating to individual nurses practice. This created a real interest in law and led to her writing her second book '*A Guide to the Law for nurses and midwives*'. The concept of accountability is integral to working within the law, and so this became an interesting concept for Marie to explore.

In 1989 Marie was appointed Registrar and Executive Director of the Nursing Council, a position she held until the Nursing Council was

restructured in 1994 and then after a brief period as Registrar, Marie left to establish her own business.

NZNA has played an important role in Marie's life, beginning with her involvement in the Student Nurses Association. She was on National committees, President of NZNA, 1981 – 1982 and represented New Zealand at ICN regulation workshops. She maintains her links with ICN and has written guidelines for ICN related to Standards for nursing education.

The development of a sense of autonomy and accountability for Marie is intimately linked with the context of her work. As a public health nurse (functioning very much as an independent practitioner); as a nurse teacher (with a focus on community health emphasising the need for standards and quality assurance); as an activist in NZNA; as an author (with a mission to inform, writing about nurses and nursing from an historical perspective, and then about nurses and the law and issues of regulation); and as a nurse adviser and later Registrar and CEO of the Nursing Council (with concern for standards, and professional accountability).

As we explored the meaning of the terms autonomy and accountability – it reinforced for me the dangers associated with just how easy it is to use a term within a professional context assuming a universal understanding and agreement about its meaning and significance. The focus of our discussion was the concept of accountability and responsibility initially developing out of decision making.

Common patterns mentioned by other participants included the weight of responsibility in her student days, the gradual understanding of individual accountability, and the importance of responsibility for one's own actions.

When talking about the importance of what decisions were being made as a student nurse and the responsibility associated with such decision-

making, Marie was conscious of the accountability associated with such responsibility very early in her career. For example the weight of responsibility she carried as a student nurse was significant and provoked considerable anxiety for her.

When it became your turn to be on night duty in a busy surgical ward as a student nurse...you were on with a senior nurse but you very early at that stage learned to be a bit anxious. To think about the fact that one day you were going to be the senior nurse on (duty) and you were only going to be in your second year then.

(Burgess, 2:2)

During the time Marie was a student nurse there were so few R.Ns available that those R.Ns working night duty were effectively supervising students. They were called 'Night supervisors' on the 'night run' and that indeed was what it was – the Supervisor doing her 'rounds' from ward to ward and running from one ward to the next when the unexpected happened.

You were always frightened that somebody was going to die in the night and you hadn't got around and done everything...That responsibility and that aspect of when to call the doctor and so forth – what if you were disturbing him and all that –you really did have to be sure of the reasons that you were maybe calling the individual medical practitioner in the night...That would be when I was the most conscious of decision-making – the weight of the responsibility.

(Burgess, 2:2)

The responsibilities and expectations placed on mostly young women straight out from school is horrifying to me in retrospect. No wonder those R.Ns in senior positions of responsibility, who were aware of the importance of standards and accountability and the mandate to the public

to provide safe care, fought so hard to change the system. The decision-making required by the student involving notifying the doctor, calling them out in the middle of the night and dealing with distraught relatives really required a very high level of responsibility for which we were not well prepared.

The aspects of people dying as well and that whole aspect of calling (ringing) people and dealing with the relatives. But I don't remember anyone saying –this is how you do it and those sort of things. You very much learned from the people you worked with and how they dealt with things.

(Burgess, 2:2)

Marie was clear that it was not just on night duty that the weight of responsibility was an issue and raised her personal awareness of a sense of responsibility. Indeed it was what seemed to be the quite significant responsibility that nursing students had in their day to day work under the system of hospital based training in the 1960s. During this time however, it was widely assumed that the doctor carried the ultimate responsibility for the patients.

This common perception may well explain why some doctors even until recent times failed to acknowledge the idea of nurses being accountable for their work (Clinton, 1987). What did nurses do to inform doctors of the changes that were taking place within nursing? What did nurses do when the doctors disagreed with nurses taking responsibility for nursing decisions? Did we work hard enough to get agreement (even among ourselves) on what comprised a 'nursing decision'?

It was really something that sort of bothered me a bit I suppose, but I...really only developed that in an escape from out from under that problem through work for NZNA.

In the 1970s when we were developing standards, and the consciousness that in fact we had to be responsible as a profession for our actions and you know filtering that out and helping nurses to become responsible...Of raising the consciousness of nurses at that time to being responsible for our own practice.

(Burgess, 2:3-4)

Marie outlined that in her view – there were many specific instances following which individual nurses have become very conscious of the importance of accepting responsibility and accountability for their practice. This was especially so when the nurse initially thought they could do something and when it came down to it and something went wrong – the doctors had ‘disappeared into the woodwork’. The example she used to illustrate this point was to do with administration of medications.

When nurses have done things through telephone orders, or where there has been an understanding that they could do things with drug medication and when things have gone wrong, and of course things haven't been clear...they've had to be responsible for what they have done... when the doctor has said 'no, that's not what I meant, or whatever', then the nurse is left high and dry.

(Burgess, 2:4)

It is the issue of confusion around the legality of nurses following written protocols pertaining to drug administration that has led to the resurgence of interest in nurse prescribing. The Health Commissioner has expressed a view that some of the processes and protocols we currently use in the hospital setting may be unlawful, and we need to address this.

While Marie was unable to think of anything in particular that has triggered what she perceives as a growing awareness of the profession as a whole regarding the concept of accountability, a number of events may

have contributed to this development. These include international influences – writers and visitors to New Zealand, the NZNA work on Standards for nursing practice, nursing services, and nursing education; global trends linked to nursing regulation including competency based practising certificates and continuing education credits; and the recent work of the Nursing Council in the development of a Code of Conduct for Nurses and Midwives as a guideline for practice (1995).

For the past three years Marie has worked as an independent consultant offering workshops and seminars relating to professional development. In response to my question about whether autonomy and accountability are still issues that get raised in her current seminars and workshops, Marie commented that this did indeed happen.

I think probably at a different level...There seems to be a greater number of people conscious of it [accountability and responsibility] but yes, I mean in teaching and things that I've done even in the last three years – seminars that I've done myself – responsibility and accountability have been issues that we've discussed as concepts. There seems to be a greater awareness of the need to be up to date with things like the whole [issue of] regulation of the profession, what we are required to do as nurses.

(Burgess, 2:6)

Marie used as an example of this growing awareness her attendance at a conference for those working with older people.

I mean I'm just thinking of the Gerontology conference I've been at for the last couple of days. The number of people who came: one - to get the books, and look at what's available in that area; and two, the people who said you know 'I found your talk helpful and useful'...

It wasn't just in passing...some of the things people want to talk with you about seemed to me they are much more concerned about the wider issues, of their responsibilities in keeping up to date, in trying to keep up with things. I'm talking about people in aged care – people who are in rest home areas - now to me that's quite significant.

(Burgess, 2:6)

In the 1970s-1980s while it was common to promote issues of quality and standards in the large public general hospitals, the private hospitals and rest homes were less involved in inservice education of their staff (Personal experience). The 1990s have seen a real change with the private hospitals leading the way with accreditation of their facilities and systems, and providing educational opportunities for their staff. Marie commented that the growing awareness in relation to accountability in the private sector was indicative of significant change and development of the profession as a whole.

To me that [awareness] reflects an accountability of being responsible as a nurse, and being aware that they have to be accountable for their practice and the practice of the people who work in their rest homes or private hospitals...It's an interesting reflection I think on the profession as a whole if it has filtered to areas like that where I think traditionally people have thought that care of the elderly was like – a little bit of a backwater and as long as you were providing good safe basic nursing care – you can't get into too much trouble...For those people [something like 360 registrants] to be so very interested and concerned about the responsibilities – legal and ethical responsibilities is very significant for the profession as a whole.

(Burgess, 2:7)

I explored with Marie the growing awareness over time of nurses and nursing, as the issues of accountability and autonomy began to be written about in international and national journals, spoken about at NZNA conferences and NERF workshops, and efforts were being made to raise the consciousness of nurses throughout New Zealand.

While Marie's career as a public health nurse, and with NZNA had raised her personal awareness of the accountability of the nurse, it was not until she joined the staff of the Nursing Council that she increased her awareness of the significance of accountability, and realised that nurses weren't all perfect.

When I went to the Council...I'd been working with the association on standards...and I thought nurses were wonderful people and this is what we strove for and what a wonderful profession. It was something of an awful shock to go to the Council and find that nurses in fact can do terrible things to people - their patients.

(Burgess, 2:13)

It was Council work and familiarity with legislation and 'where the buck stopped' that led to the start of a mission for Marie – to raise awareness of the accountabilities of the nurse among the profession.

The start of a mission to help educate nurses and make nurses generally more aware that we are accountable for our practice. We are accountable to the Council and to the wider public...not just to the patient but to the wider public, through the legislation and that we really can't hide behind anybody's apron at all. In fact I think many nurses in many situations have become very conscious of that.

(Burgess, 2:4)

To bring her mission to reality Marie has published books and booklets relevant to the New Zealand context, and currently works as a consultant including co-ordinating seminars exploring issues such as the law and the nurse, and professional responsibilities. In 1989 she published through the Nursing Council a booklet on the disciplinary and disability process interpreting the Nurses Act. This was to assist the Nursing Council members as well as the nursing profession and employers, as prior to this publication the process was only spelt out if you became involved in it – by making a complaint, or being the subject of a complaint.

Prior to that [the publication of the booklet] there wasn't anything for people who in fact weren't subject to it. I mean if you were involved in the process – either through making a complaint or being the subject of a complaint, then of course you learned about the process, but you couldn't come along as an interested person and say 'What is this? How does it work?' There wasn't anything...so that was very useful for the Council members who came on [elected or appointed to the Council] and also for anybody else like the CHE's or Principal Nurses to actually purchase; to have something they could turn up and look up. Going on from that – that's when I became more involved in writing because of the questions that so often arise from people ringing up for telephone advice on their responsibilities in relation to legal requirements.

(Burgess, 2:5)

This is a useful example of how an experience (working for the Nursing Council) can influence attitudes and/or beliefs (realisation that some nurses 'do terrible things to people') and led to an effective response (work and success as a writer).

The writing continued from perceived need. As a nurse adviser for the Nursing Council, Marie received many calls and enquires from people seeking advice on responsibilities in relation to legal requirements of nursing and midwifery practice. There were a few international books written on the nurse and the law but the days have long passed when work (particularly law) from another country can be used without qualification to apply to the New Zealand scene. This demand for information led to the 1993 publication of her book 'A guide to the Law for Nurses and Midwives', a New Zealand resource that not only met her own needs for a reference source that applied to the New Zealand context, but was designed to be of assistance to nurses and midwives in practice as well as to nurse educators

How did Marie assist others to develop a sense of autonomy and accountability?

With a mission to help educate nurses and make nurses generally more aware of their accountabilities as a nurse, I asked Marie how she assisted others to develop a sense of autonomy and accountability?

Through the work for the Association in the 1970s when we were developing standards and the consciousness that in fact we had to be responsible as a profession for our actions and filtering that out, and helping nurses to become responsible...A lot of our conferences and the Travelling Fellows we had, starting at that time were associated with that topic – of raising the consciousness of nurses at that time to being responsible for our own practice.

(Burgess, 2:4)

Her commitment to a philosophy of always working to improve, to do better within the profession, has always been strong. Marie described her belief that we have a collective responsibility to ensure all nurses are aware of standards and work to attain those standards. It was when Marie

was CEO of the Nursing Council that work on the Code of Conduct began, one way of raising the awareness of all nurses in New Zealand.

[We need] to get that message across to the great number of the profession. It's not just about going to work and doing it right on the day and going home, there are broader principles at work and we must all have a commitment to those...Unless there is ongoing education for all members of the profession [not just those members of the profession where things go wrong and they don't meet the standards], that there are these standards, these are what we should be working towards and attaining...it seems to me that we don't grow as practitioners and as a profession. It's part of the regulation of the profession, if we don't do that ourselves, then somebody else is going to come along and do it for us.

(Burgess, 2:11-12)

While I applaud the ideals expressed by Marie, I am concerned that we are a long way from gaining universal acceptance by the profession that Standards of practice, and an ethical approach to practice are important and need to be fostered. Evidence from the public record, the participants in this study, colleagues, and personal experience, would suggest that we still have a critical mass of nurses in New Zealand who do indeed 'just go to work, and do it right on the day'.

This second vignette has focused on the concept of accountability. It provides a picture of a developing understanding and interpretation of what it means to be accountable, from the days when Marie was a student first glimpsing the breadth of responsibility we have as nurses, to her work as a writer with a clear purpose and vision to help educate and make nurses generally aware that we are accountable for our practice.

The opportunity to share the insights of two of the participants as they reflected on their understanding of the significance of autonomy and

accountability provided a sense of how some nurses over these four decades sought to develop their own sense of professionhood, and to support the profession as a whole as they grappled with concepts of professionalism and how to move forward and contribute to society. I was increasingly aware as I analysed the written and oral texts of the impact of experience and maturity on our attitudes and beliefs, as the journeys of the participants unfolded. Without their stories the primacy of the nurse may not have been so clear.

Concluding remarks

In this second theme, square two on the surface of the quilt, I have explored the idea of an emerging sense of autonomy and accountability.

The primacy of the nurse revealed in the previous chapter through the skills of effective decision-making was not sufficient on its own. Decision-making without autonomy and accountability will not be enough to ensure the powerful influence of the nurse.

The written and oral texts have revealed how nurses in each of the decades have exercised autonomy and accountability and it is worth noting just how much has taken place over this time period regarding these two concepts. This development was seen by exploring changes in practice and education as well as in writings in journal articles and texts that revealed the thinking and debate over time, as individuals and the profession sought to understand the implications of autonomy and accountability for professional practice. Issues raised by Ethical codes and Codes of Conduct developed by the profession added to the debate

Nurses in New Zealand are challenged by the search for meaning and understanding of autonomy and accountability just as nurses are in other western countries such as Australia, the United Kingdom, and North America. The global debate is an international challenge to the nursing

profession, and New Zealand is neither behind nor ahead in the thinking and exploring necessary to meet the challenges in a rapidly changing environment. Primacy of the nurse is expressed through professional autonomy and accountability so we need to be very clear about just what the two terms mean.

I have explored many of the ideas from the material sources and demonstrated how the nursing profession can learn from both the written and oral texts about the confusion in the minds of many nurses related to the meaning and understanding of autonomy and accountability. How some nurses regarded autonomy and accountability as synonymous, while others had difficulty with the concept of autonomy of the nurse in a context of partnership or collaborative practice. The texts reveal that autonomy and accountability as concepts were not widely considered until the 1970s when nurses began to look more at nursing in New Zealand as a profession, and to explore the characteristics of a profession. We thought about the need to separate out nursing from other health disciplines. As the participants commented we sought to explore how we were different from other health professional groups searching for the place of the nurse in the health team

The oral history participants were women seeking to make a difference through their contribution to nursing. Autonomy and accountability were important to them in the daily expression of their professionalism. They were concerned with the bigger picture of the profession as a whole. Some wrote influential papers and texts that added to the debate as well as influencing changes over this time in the bigger picture, as they participated in the work of the Department of Health, NZNO, and the Nursing Council. The 'little picture' of how they individually worked in their personal professional practice enabled them to demonstrate aspects of nursing that they valued. They strove to build their skills as professionals and their knowing about professionhood. We can learn from

them something of their primacy in their leadership of the profession over this time – how their grappling with concepts as they matured, their personal efforts in seeking to build their understanding and expression of these particular qualities - enabled them to effect change. What is very interesting about their oral accounts is how they identified that the search for professionhood was a characteristic of their period – a significant part of their actions over the four decades.

Once again the oral history participants revealed a concern for the profession as a whole, the need to build an understanding of autonomy and accountability in the wider nursing world. They revealed the efforts some of them undertook in order to bring others along in education and clinical practice. These were challenging nurses who sought to build professional performance in all areas of practice within the profession.

This period of time in relation to autonomy and accountability revealed how significant an understanding of professional autonomy was and the concern for professional accountability. Decision-making without autonomy and accountability will not be enough. Decision-making supported by an informed sense of autonomy and focused on the need for accountability will build practice for the individual nurse, and strengthen the profession. We need to have sufficient sense of our autonomy as a nurse to be free to act, free to respond to nursing decisions, to support the primacy of the nurse. Alongside that sense of our autonomy, we need to be clear about balancing our responsibility for the multiple accountabilities expected of the individual and the profession.

What is interesting from the oral history participants' accounts is that they came to understand that they could act autonomously and exercise accountability while seizing and responding to initiatives. Across the decades the nursing contextual movements and changes enabled us to evolve our understanding in the sense of learning to grasp what was

possible – to seize and develop skills in practice. This demonstrated the resilience, passion and commitment nurses needed to assist and support other individuals and the profession, building their skills and confidence, and overcoming apathy.

From these written and oral texts it is clear that nurses all over the world as well as in New Zealand used both their skills in decision-making and knowledge and understanding of autonomy and accountability across the period. This led to enhancing the development of the profession, and by clarifying the scope of nursing practice, enabling the profession to move forward through time. This understanding and willingness to actively respond helped to create a momentum for the changes and development across the decades.

The participants were very clear about accountability to patients, and recognised that multiple accountabilities impacted in the 1990s in response to the regulatory environment. This raises awareness both of the primacy of the nurse and of the need to think carefully about the boundaries of practice, recognising that if we step over the boundaries we will certainly be called to account.

Another issue raised by the oral history participants is that of societies changing expectations in regard to accountability. In the 1960s, 1970s, and even some of the 1980s, most of society accepted that professionals knew what they were doing, as they worked in service to society for the good of the peoples of New Zealand. As outlined on the written and oral texts recent times have demonstrated that this was not always the case. While nurses still topped the ‘respect poll’ society is now more questioning of the attitudes, beliefs, and responses of doctors and nurses, expecting them to be clear about why they suggest a particular approach and to be accountable for their actions. Both the individual and the profession need to continue to be aware of the social mandate we have

been given. We must continue to live up to these expectations to support the primacy of the nurse.

There were some interesting differences within the written and oral history participants' accounts that characterise for me some of the challenges regarding autonomy and accountability in terms of the profession's effectiveness. The written texts reflected the professions concern to build the profession, to move the profession along as a whole, the primacy of the nurse as a whole within the profession and to be able to act effectively both autonomously and responsibly. The participants revealed more of the powerful potential of individuals acting with intent, reflected in their fascinating accounts of where they acted autonomously and accountably in confidently seizing the moment and they got on with what needed to be done day to day. We can understand from the nurses over these four decades how nurses have worked to address autonomy and accountability within nursing practice from both the individual and the profession's perspectives.

Decision-making supported by a clear sense of autonomy and grounded in accountability begins to build a firm base for individual practice. This foundation also enhances the growth of the profession, and from both the practice and the professional aspect it is clear that the primacy of the nurse is revealed.

Chapter Six: Nurses as a driving force

We all come to the dance with a varying set of experiences. We've travelled differently, we have aged differently, and thus we have different visions.

(Chalke, 1996)

The third square on the surface of the quilt builds on the previous chapters as part of the interpretive circle to now explore the questions of 'why' and 'how' particular nurses can and do make a difference and effect change. The attitudes and beliefs that help us **be** a driving force either as an individual or within the profession as a whole are explored in this chapter.

A view of the nursing world nationally and internationally through the interpretive strategy of utilising written source material and the voices of the oral history participants was created in the three previous chapters – the context chapter and the first two theme chapters. Sifting this material through four contrasts, big picture/little picture examples, national/international trends, time within and between four decades, individual/professional perspectives, enabled this view to emerge.

The nursing context included the current meaning and use of the term 'nurse' in New Zealand and changes over four decades in nursing education and clinical practice. Concepts of the NZRN making nursing decisions that are 'crisp and timely' and made with the confidence that ensured nurses individually and professionally can move forward, make progress and contribute to the health of the peoples of New Zealand were detailed in the first theme chapter. The second theme chapter clarified the importance of an understanding of personal accountability for these

nursing decisions, and the consequential actions taken to move forward, with an emerging clarity of the concept of professional autonomy in a context of collaborative practice.

A perspective of changing attitudes beliefs and responses of nurses that make the difference, was provided in the two theme chapters, 'Nurses' decision-making: changes over time' and 'An emerging sense of autonomy and accountability'. The concept of the primacy of the nurse, in the sense of nurses take opportunity to change and grow, growing in confidence in their ability to seizing the moment to act and make things happen, and making a difference, began to surface in the three previous chapters. The primacy of the nurse becomes explicit in this chapter, as the attitudes and beliefs that support ability to make things happen, to be actively responsive to the context, emerges. I have called this ability a 'driving force'.

The idea of 'Nurses as a driving force' explores the concept of why and how individual nurses or groups of nurses made a difference, made an impact, took a stand or generated support to drive toward a goal. They are 'drivers' in the sense of actively responding by making decisions, taking action, leading change, enrolling others and moving forward to influence the direction of both individual nurses and the profession as a whole. They are also nurses who accepted responsibility for their decisions and their actions. Being able and willing to make effective decisions within a context of professional autonomy and accountability is not enough to move either the profession or the individual nurse forward – what is required is a 'driving force'.

The major source of material for this chapter was the voice of the oral history participants. While there is some writing about leading and leadership in nursing related to prerequisites and outcomes which I have used, I have found little that explores the idea of an energiser, a driving

force that could be found in all of us, and the attitudes and beliefs that would help achieve progress. I have, however, used the text by Schorr and Zimmerman (1988) *Making choices taking chances: Nurse leaders tell their stories* as a source of the biographical stories of forty-six USA nurse leaders. This text records the personal reflections each of the forty-six nurses, and includes comment on many of the attitudes and beliefs that underpinned their practice. The text provided me with an opportunity to contrast national and international perspectives when exploring the motivations that energise and assist nurses and nursing effect change.

Using the interpretive framework and the process of sifting the source material through the series of four contrasts, four content areas were revealed. The first area was the idea, under the theme of ‘nurses as a driving force’, of nurses in charge, nurses in charge of their attitudes, their values, and their responses – their destiny. The second area was the individual learning related to how and why nurses drive, and the third area revealed the attitudes and beliefs of nurses taking charge, nurses making a difference. The fourth area was the insights that individual nurses and the profession might gain from the attitudes, beliefs and responses of nurses who are drivers (Figure Six: redrawn below)

As stated in the methodology chapter under the principle that the use of oral history as method can provide access to a past, present and future lens that often enhances our understanding, the first assumption was that the oral texts of the participants will add a perspective that is not readily available in the written texts. Working through the source material I became aware that the participants' accounts added a particular phenomenon that was surprisingly absent from most of the public records and written texts. This was the phenomenon of nurses with a passion for nursing, nurses with real commitment for getting in there and making things happen. This chapter enables me to make explicit the attitudes beliefs and responses that I believe are prerequisites if nurses and nursing are to make a real difference.

The flow of the chapter begins with how I have interpreted the term 'driving force'- answering the question, what is a driving force? I have chosen to explore whom some of these drivers were – individuals, groups and organisations in New Zealand, and to describe how they acted as nurses taking charge influencing individual nurses and/or the profession. I then sought to understand the 'why' question. Why are some nurses energisers? Why do some nurses make things happen, while others do not. Is this a deliberate choice, or a missed opportunity? If it is important for nurses and nursing to understand why nurses are drivers, then it is equally important to know 'how'. How do they drive? What are the attitudes or beliefs of those nurses taking charge?

One of the important themes revealed during the analysis of the oral histories and supported by the USA nurses' stories, was the consistent mention of individual nurses with a clear purpose and vision taking a lead, influencing and moving others forward, often with enormous energy and a strong commitment to the profession. Aydelotte (cited in Schorr &

Zimmerman, 1988) described how as she matured professionally, she developed a set of beliefs about the profession and her role in it, forces that drove her on, and she learned

to look forward, to dream of what may be possible while keeping in mind the events that have gone before and the current environmental forces that will play on the realisation of that dream.

(Schorr & Zimmerman, 1988, p.13)

Internationally and nationally nurse leaders for many decades have directed, driven, or led major change such as the development of ICN 'the international idea', nurse registration to protect the public, the movement of nursing education into the university setting, the development of the profession, health promotion within communities. In addition to describing nurse drivers who made things happen from a position of authority, some of the participants also talked about the 'every day' driving force. The driving force that is a steady unremitting constant driving, for example an influence towards some form of excellence of practice that *'moves the machinery just as much as the high profile driver'* (Shadbolt, 2:11).

Over the last 100 years the theme of nurses making things happen, energising the profession, was supported in the readings from the nursing literature, both internationally (Abel-Smith, 1969; Bridges, 1967; Kalisch & Kalisch, 1975; Lynaugh & Brush, 1999; Russell, 1990; Schorr & Zimmerman, 1988), and nationally (Burgess, 1984; Salmon, 1982; Neill, 1961; NZNA, 1984). Writing about the contribution of nurses is also found in the reports written by nurses who travelled internationally, or from those who visited New Zealand as consultants or travelling scholars. The individual stories of the participants enabled the piecing together of particular attitudes, beliefs and responses that characterise the theme of

‘Nurses as a driving force’, and the primacy of the nurse and formed the third square on the surface of the quilt.

What is a ‘driving force’?

In exploring the idea of what the words ‘driving force’ might mean, examples are used from written texts to support the idea of a driving force as an energiser, someone that makes things happen, that gets the job done.

The participants described the concept of a ‘driving force’ in a variety of ways. They described driving forces as external, a force that influenced nurses, or internal, nurses as the force – the influence. External forces included education, career choices, or a timely opportunity for the individual nurse, and social movements like the womens movement, or a world-wide focus on regulation or leadership for change, for the profession as a whole. The effect of the collective as a driving force, versus the individual as a driving force, was another interesting perspective.

I think there is no doubt there have been nurses, individuals who have been driving forces right through the history of nursing, all over the world. There have been times in different countries where nursing collectively has become a driving force in order to bring about some significant change...In nursing education...In socio-economic welfare...In negotiation rather than confrontation...The challenge now of course is for nursing to become a driving force not just for change within nursing, but in health care - in the broader health care environment.

(Shaw, 2:12–13)

In this account I am using the term ‘driving force’ as an energiser –a force moving forward, making things happen. I am also using the term to refer to an internal force, the nurse as the driving force either individually or

collectively rather than an external force influencing nurses. This does not deny that external factors can be drivers, indeed this chapter will include reference to such influences, but the primacy of the internal force – the force within the nurse is the view I wish to showcase.

A driving force requires clarity of purpose – a reason for being or doing. It includes components of vision, passion, and commitment to and for a cause. In relation to nurses and nursing, those nurses with a clear purpose, with vision, passion, and commitment, stand out in the profession. They stand out because they make things happen. They make things happen because they have the confidence to make decisions along the way, and are prepared to be accountable for those decisions.

These nurses are found everywhere. In the community clinic, on the Marae, in the local resthome caring for older people, in independent practice, working in teams with other health professionals, and in acute care settings. Some nurse drivers are in leadership positions, positions of authority, while others drive through their ability to enrol those around them to see value in contributing in a particular way, in a particular setting. As a community nurse working with children and their families to enhance their understanding of living in a more healthy way; a nurse working in the area of mental health supporting a person through a life crisis; a nurse working with older adults and creating an environment where the older people feel valued and cared about. All such nurses make a positive difference to the health of New Zealanders.

These nurses spend or have spent time and energy developing and sharing ideas with all that will listen (and some that will not!). Sharing their vision with other nurses, other health professionals, health providers, and the public, politicians, and policy makers. They enrol others with their enthusiasm and other nurses begin to see value for themselves in participating. Their individual visions were different according to the

context of the day, especially changes in the role and status of women, changes in concepts of health and illness, changes in healthcare systems and practice, and changes in nursing education.

Many of the early examples of nurses in New Zealand who made a difference were able to look forward to the future and committed their efforts to creating a future for nurses and nursing. In 1978 the *NZNJ* reported on a keynote address celebrating the 50th Jubilee of the New Zealand School of Advanced Nursing Studies. Elisabeth Orbell (1978), a past Principal of the School, asked the audience to remember those who made the future possible –

These wonderful women of the past who recognised the need and gave NZ a nursing service of which the country can be proud . Grace Neill, Hester MacLean, Jessie Bicknell, Amelia Bagley. Mary Lambie, Janet Moore, Ruth Bridges, Flora Cameron and many others. Without their vision, enthusiasm, fighting instincts and complete dedication to a better education for nurses we would never have the high standard of nursing service that is taken for granted today.

(Orbell, 1978, p.18)

These named nurses made things happen by building on their ability to visualise what the future might be, and make decisions to move in the desired direction. Using the term ‘driving force’ as an energiser –a force moving forward, making things happen, the next section explores who some of these drivers were, and who were the nurses in charge?

Nurses in charge: Who are the drivers?

Nurses who are drivers are everywhere. They are all over the world. They are single individuals or small groups of nurses, they are in small or large organisations, in national or international organisations. They have

themselves been influenced and moved forward along a pathway, and are now influencing others. Throughout nursing history in New Zealand, individuals have led and driven nurses and nursing. This section will briefly outline who some of the key drivers were, as individuals, small groups, or organisations.

Individuals making a difference.

Individuals as nurses who make a difference effecting positive change cover a wide range of nurses in a variety of settings relevant to the context of the day. Nurses who make a positive difference today are not confined primarily to those in positions of authority as they were in earlier decades. It is interesting to consider who these drivers were over time, and how the 'power' and influence changed.

In the 1960s, those who made a difference were predominantly in positions of authority or with knowledge of the discipline of nursing through travel and study. In the 1970s with a growing confidence by nurses in New Zealand, those making a difference and moving the profession forward were often found in nursing organisations or Government departments. These included NZNA, the newly formed autonomous Nursing Council, the School of Advanced Nursing Studies, as well as those on the Division of Nursing within the Department of Health. The 1980s saw local Heads of Schools of Nursing, and leaders in clinical practice begin to lead the way, to put forward ideas for debate, and in the 1990s nurses making a difference could be found everywhere, working as a nurse or using their nursing skills in other 'non-nursing' roles.

While there were some 'nurses' in the earlier times who tried to make a difference without positional power, the system was too strong, and little progress was possible for most. The shift from the major influence by nurses in centralised positions of authority, to individuals found in a wide

variety of settings, seizing the moment and making things happen, is interesting and an important issue when we consider learning from the past to inform our future.

In the 1960s the individuals who were key drivers were mainly those in positions of influence in central government, the Director of the Division of Nursing and her staff, and those who travelled internationally.

The position of the Director Division of Nursing – the highest status position within nursing for a nurse to aspire to during this time, was one of *such power that nurses today probably could not visualise (Nan Kinross, 1:1)*. A woman (and they were all women) who had her fingers (indeed her arms up to her elbows) in all aspects of nursing. The Matrons of the public hospitals kept her informed and met regularly with her. Along with the Director General of Health, (always a Doctor and until the present appointee always a man), the Director Division of Nursing was responsible for the appointment of the Matrons and had the power to instruct a nurse to take up an appointment in any part of the country. She used the power of her position to make things happen.

Nan Kinross spoke of the time she was instructed by the Director Division of Nursing to apply for a position as Supervising Matron to a particular Hospital Board and there was just no question that this would be so. Personal plans or interests just did not enter into the decision made from on high. Within the culture of the day there was no such thing as consultation, let alone negotiation.

Anne McDonald and Margaret Bazley described similar experiences. Anne was working as a district nurse and was asked three times to go to the New Zealand Post Graduate School. She had refused twice before, as she wanted to stay in clinical practice. Her refusal was because she knew that once she went to the School this would probably change.

The only reason [that I refused] was that I knew that would be the end of nursing (hands on) and I would have to teach...[On the third occasion] I knew that the time had come...you have got to do this – and as I had to wait over a year to commence the next course I was taken from District Nursing and put in charge of the Preliminary School for the intervening year.

(McDonald, 1:1)

Margaret Bazley was a student in the Post Graduate School in Wellington in the 1960s with a brief from 'on high' to prepare to set up and run a specific postgraduate psychiatric nursing course on completion of her study. Several weeks into the course she was called to see the Director Division of Nursing and subsequently the Director General of Health and told that she was to change from the nursing education stream she was currently studying and to move to the nursing administration stream of the programme. This was specifically to enable her to prepare to be the Matron of a Psychiatric Hospital on completion of the programme.

The power of the Director Division of Nursing in the 1960s was felt not only by individuals, but also by all the major nursing organisations of the day. The Director Division of Nursing was the Executive Secretary of the Nurses and Midwives Board, and very involved in the NZNA. As Nan Kinross stated, the person in this position owned the lot. Her power as a driving force was considerable and this remained unchanged until the three organisations and their representatives were separated in the late 1960s early 1970s.

The second group of individuals who were key drivers in the 1960s were those who had travelled internationally. In the late 1950s the British Commonwealth Nurse Fund was used for further training and development of New Zealand nurses. Nan Kinross described 'a wave of people' going overseas in the late 1950s early 1960s. "*Thelma Burton and*

Elsie Boyd to the United Kingdom, and Betty Orbell, Alison Cathie, Bea Salmon and myself to the USA” (Kinross, 2:7). Individual nurses travelled usually for a specific purpose such as a course of study, or to observe some particular aspect of nursing, and came back eager to share their experiences, or to gather ‘disciples’ around a cause. Such causes in the 1970s were post-registration nursing education, the perceived need being for nurses to align themselves to the value of life long learning, and to developments in the discipline of nursing. These nurses made decisions on their return to New Zealand to contribute to the future development of nursing and worked alongside others to make things happen.

In the 1970s the individuals who were leaders were now those working in New Zealand. Individuals like those mentioned above, putting into effect the ideas they had learned from overseas or working collectively through the New Zealand Nurses Association, in partnership with the Division of Nursing in the Department of Health, the Nursing Council, and the School of Advanced Nursing Studies. One such example of collective energy was the transfer of nursing education from the Hospital Board schools to the Tertiary education sector.

In the 1980s the locus of power and control had shifted. Moves to decentralise saw individuals with leadership skills able to create results found in the clinical practice arena as well as the Heads of the increasingly powerful polytechnic schools of nursing. Nurse Consultants and Clinical Nurse Specialists were leading clinical practice decision-making and for the first time in New Zealand the opportunity for a career in clinical practice as opposed to careers in education and administration was a reality. The polytechnic Schools of Nursing established a focus with undergraduate nursing curricula as well as opportunities for post registration studies.

In the 1990s individuals leading were found everywhere, as nurses began to acknowledge that it is through clear purpose, vision, and commitment that results were achieved. Health care organisations are full of nurses, taking the opportunities that opened up in many spheres. In central and local government politics, policy direction, policy implementation, with health funders and health providers in both the public and private sector, in risk management organisations, social policy agencies, and not least as consultants and individual entrepreneurs. They made decisions to seize opportunities, and prepared themselves to accept the responsibility associated with change. Nurses taking charge, nurses making a difference.

Groups making a difference.

Significant groups that acted as drivers included small groups of nurses with a common cause or interest that led them to act, nurses who saw a specific need for action and made it happen, and those who studied together and formed influential network groups. The period of this study has many examples of small groups forming in different eras to meet the needs of the day. Energy to make things happen is needed to action ‘little things’ as well as ‘big things’. Little things like getting the bedroom doors painted different colours in a gerontology unit to assist patients identify their personal space, or deciding to establish a ‘journal club’ within a clinical setting. The participants raised examples of effective small groups over the four decades as they shared their commitment to making things happen.

Nan Kinross believed that one of the most influential small groups in the longer term were those who spent a post registration year together at the School of Advanced Nursing Studies (SANS) in Wellington. Throughout the 1960s and 1970s until the school closed in 1978 the cohort groups set up networks that played a major part in the development of nursing. The networking and support systems for some of the groups became lifelong

activities. Nan described the significant influence of many of the people who knew each other through the school, working together for educational change culminating in the visit of Helen Carpenter, and the effective result in our education system. Ann Nightingale also spoke of the effectiveness of this group who were in strategic positions around the country and stimulated activity everywhere.

Anne McDonald described the small group of nurses in Wellington, led by Jocelyn Perry who through their foresight and energy set up the C. L. Bailey Nursing Education Trust in the 1970s and played a crucial role in ensuring the establishment of the University programmes at Massey and Victoria. Nurses were told there was no money and Anne recounted that Jocelyn Perry, a tutor at the New Zealand Post Graduate school, was so determined that this time money would not be the issue, that she stated that she would get the money. She sought funds from local businesses and was one of the key drivers in the establishment of the Trust, and money being made available to both universities.

Another example was the group in Auckland who spearheaded the successful 'Nurses are worth more' campaign in 1985 after the wage freeze. Led by three Auckland nurses Bronwyn Herbert, Gill Coombes and Mia Carroll, a co-ordinated approach in the Auckland region developed into a national campaign. The group arranged meetings in Auckland that were attended by hundreds of nurses, they set up a fund, hired a bus to take a group of nurses from Auckland to Wellington to speak to the NZNA conference delegates, inspired the delegates to then march on Parliament. As well as contributing to a successful outcome for nurses financially, the process led to more effective lines of communication developing between the NZNA national executive and local branches (Smith, 1998). The 'Nurses are worth more campaign' is a good example of how a small group of nurses with a clear purpose, with commitment, energy and passion about the value of nurses influenced the

wider nursing group, eventually gaining support from the public sector union movement, and politicians. This small group clearly demonstrated confidence, courage, and effective decision-making in response to a clearly articulated cause.

During the 1980s-1990s many small groups with common interests saw the need for collective dialogue and support and established themselves. Some were special interest groups within NZNA, while others formed groups to meet their particular needs in a different way (refer context chapter). Jocelyn Peach (see later in this chapter) shared her experience establishing the Nurse Executives of New Zealand group out of a perceived need to support nurse leaders and demonstrated how if the intention was clear, energy and commitment to act make it happen.

Other examples in the 1990s include groups establishing clinical career paths for their organisation, negotiating salaries and conditions of work, and establishing new ways of working within the health sector (e.g. A 'shared governance' model in a large metropolitan hospital, independent practice groups in small centres, pilot nurse rural health schemes.)

Evidence of the primacy of the nurse in the work of small groups passionate about a cause was all around us. It began with a vision of what might be possible, and became a reality when nurses made a decision to proceed and were actively responsive to the context.

Organisations making a difference.

Organisations can also function as a driving force. Internationally at different times in our history, WHO, ILO, and ICN have all been influential as drivers affecting nurses and nursing in New Zealand (NZNO, 1984).

In New Zealand national organisations involving nurses have come and gone with their sphere of influence waxing and waning according to the

context of the day. Significant organisations that were perceived as influential over time have included the Division of Nursing within the Department (now Ministry) of Health), NZNA, (now NZNO), and the Nursing Council. Examples of the role of two of these organisations played as drivers are briefly outlined below.

The Division of Nursing within the Department of Health was a powerful force during the 1960s and 1970s with a large staff of experienced nurses and the opportunity to lead the profession nationally from a centralised position. The Division focused on nursing education, nursing service and community and mental health. With regard to nursing education, the nurse leaders lobbied for the visit of Dr Helen Carpenter, one member accompanied her wherever she went over the three months of her visit, and after the report was published, they stomped the country talking to groups advocating the proposed changes. They lobbied the politicians and other key players (the New Zealand Medical Association and the Hospital Board's Association). When the decision was made to transfer nursing education to the Tertiary education sector, they promoted the change, wrote supporting documents, and continued to foster support for the cause.

They continued to be strategic, to act, and in association with NERF they conducted the review of nursing services to ensure that appropriate clinical practice developed alongside the changes in nursing education, working hard to develop appropriate workforce planning models to meet the needs of the health workforce.

The staff in the Division of Nursing also worked to ensure that the nursing leaders in the hospital services and community were aware of the changes likely to happen in the late 1980s. They spoke at meetings, wrote keynote addresses to help inform, and held meetings with the Chief nurses to assist plan and prepare for the likely changes. In the late 1980s deregulation and

general management systems were built into the Government departments including the Health Sector. This meant that departmental functions focused on service outcomes, and staff were allocated responsibilities on a health service basis rather than representative of professional groups. The Division of Nursing ceased to exist and the number of nurses in the department whose major function was to focus on the concerns of nursing gradually reduced until in the mid 1990s the numbers were reduced to two – A Chief Adviser (Nursing), and a nurse adviser. In 1999 there were nurses throughout the Ministry contributing to health service outcomes but only one position dedicated to nursing – a Chief Advisor Nursing. As an organisation, the Ministry functioned primarily as a policy unit and was not widely perceived as a source of nursing leadership.

The New Zealand Nurses Organisation has had its ups and downs as a driving force as it clarified its purpose. Since its formation in 1909, the organisation has been the most representative group of nurses in New Zealand. It has had an uneasy time balancing the conflicting demands of members (Carey 1984), and has moved from a centralised organisation with a network of branches to a national and regional structure with individual membership, in an effort to be more responsive to the members. In the 1970s NZNA clearly staked out its position putting the welfare of nurses first and foremost maintaining that everything affecting nursing and nurses is the concern of the NZNA, and such matters will always be the business of the Association.

Like nurses in the Department of Health, NZNO chose to focus on the perceived needs of the day. NZNO leaders called groups together to plan for the future, to strategize and manage responsiveness to legislative or policy change. It has led and cajoled its members, worked centrally through branches and then more locally as the context changed in a less regulated environment. With the interests of nurses and nursing at the

heart of its existence, NZNO has continued to move forward, to change structures, staffing, policies, and processes to suit the time period.

Margaret Bazley, in the guest editorial for the 75th Jubilee issue of the *NZNJ* commemorating the first meeting of the Central Council of the NZTNA in 1909, wrote about her relationship as former Director Division of Nursing, with the NZNA and her appreciation of the real strength of the Association over time. She outlined the value of the independent role of the Association.

At times of threat or crisis I have seen it quickly and effectively marshal the support of its membership. At other times I have been witness to its persistent pursuit of an issue until a solution is reached. There have been other times when I have known that it is only the NZNA with its absolute independence of any employer of nurses, that is in a position to stand up and speak out against issues. Other nurses who have to be loyal to their employers are powerless to act in such instances. At these times the nursing profession is absolutely dependent on the Nurses Association.

(Bazley, 1984, p.2)

There were however times when the organisation did not act as decisively as it might – where it was not actively responsive - when it was not a driving force. For example in preparing the profession to work alongside and support the new comprehensive graduates in the 1970s, preparing nurses for general management in the health sector in the 1980s, and clarifying the role and preparation of the enrolled nurse in the 1990s.

At other times it was a key driver, the energiser for the profession. For example in working to raise standards of nursing education and practice in the 1960s and 1970s, the transfer of nursing education from the hospital schools of nursing to the tertiary education sector in the 1970s, producing social policy statements and ethical guidelines on behalf of the profession

in the 1980s, and preparing members for the impact of legislation such as the State Sector Act, the Employment Contracts Act, and the revision of the Nurses Act in the 1980s and 1990s.

There are many ways to interpret the focus of an organisation whose function is clearly staked out as putting the welfare of nurses first and foremost, maintaining that everything affecting nursing and nurses is its business. How its members, other nurses, other health care professionals, health care organisations, the policy makers, and the public perceive NZNO over time will impact on its perception as a driver.

Individuals, small groups, and organisations all require the same attitudes and beliefs if they are to be actively responsive and move forward. They need a vision – an idea of future direction to guide their response. They need to decide on a way to move forward and to have the energy and commitment to make progress, to act independently, or collectively to move forward and ensure the primacy of the nurse continues.

Individual learning: how and why nurses drive?

Addressing the question of how nurses drive, it was interesting to observe what worked and what didn't work as the nurse of the day sought to move forward.

How did nurses drive?

For many individuals, they were in the right place at the right time (ready to grasp opportunities). In the preface of the text by Schorr and Zimmerman they talk about how for many of the USA nurse leaders

being in the right place at the right time in relation to choices and career changes is expressed over and over again in these pages as is the willingness to seize opportunities.

(Schorr & Zimmerman 1988, p. viii)

Similarly in New Zealand the oral and written texts revealed that nurse drivers were in positions of responsibility and had access to policy makers and to politicians. They had positional power and again the opportunity to drive, but most of all they were decision-makers.

Those individual nurse drivers, who were in the right place at the right time, included for example Audrey Orbell, Director Division of Nursing taking the opportunity to travel overseas in 1965 to negotiate reciprocity with nurses in the United Kingdom, and Margaret Bazley as Chief Nurse in the Department of Health accepting the offer of a position as a State Services Commissioner in the 1980s at the time able women were being promoted in the public service as part of equal opportunity policies. In the 1990s Judy Kilpatrick, Judith Christensen and Alison Dixon as Heads of Polytechnic Nursing Schools seized the opportunity when education legislation enabled polytechnics to offer degree programmes.

Individual nurse drivers also included those who were in positions of responsibility and had access to politicians and policy makers. For example Nan Kinross and Elsie Boyd in the Department of Health, Margaret Bazley as President of NZNA, and Bea Salmon as Principal of the Advanced School of Nursing all had a huge influence on the Carpenter Report and the implementation of the beginning of the transfer of nursing education to the tertiary education sector in the 1970s. In the 1980s Margaret Bazley and Sally Shaw worked hard to persuade the policy makers and the profession to acknowledge the value of nursing and to grasp opportunities offered within the rapidly changing times within the health sector. In the 1990s Nan Kinross, Lee Mathias, Jocelyn Peach, and others used their knowledge and expertise to influence health policy and accepted appointments as directors, advisers or consultants to a variety of organisations within or associated with the health sector.

Individuals who were the appointed nurse leaders within organisations, and had positional power, also had the opportunity to influence and make things happen. The Director Division of Nursing within the Department of Health was a very influential position up until the late 1980s when the major state sector restructuring began. Similarly the positions of Matrons or Chief Nurses within the tripartite structures of the Hospital and Area Health Boards were very powerful positions until the system of general management was introduced – again in the late 1980s. As the educational institutions became autonomous, individuals within the education sector became key drivers (Yvonne Shadbolt in Auckland and Judith Christensen in Wellington associated with the Polytechnic programmes, and Bea Salmon and Nan Kinross associated with the University nursing programmes). They were sought out to be members on national committees and started to write in the nursing journals of the day.

Acknowledging that while individuals in positional power had an advantage, they had the opportunity to become drivers, some did not necessarily take and use this opportunity as Sally Shaw outlined in the previous chapter. Attitudes and beliefs that interfere with ability to cope with change such as resistance to change, apathy, lack of self-belief, loss of positional authority, are barriers to effective decision-making and accountability.

While power to influence and change can be for the good of the whole, sometimes, positional power can be misused. Jocelyn Peach referred to the seizing of power by the individual nurse not necessarily being for the good of nursing as whole. She used examples from the time of the introduction of general management in the health sector. Because individual nurses were strong leaders many of them moved into general management in the late 1980s early 1990s. While some nurse-managers were supportive and empowered the profession others did not.

They [the ones who were supportive] were the wonderful ones because what they did was [by] using their nursing knowledge they empowered the profession and supported it. There were too many though that didn't. So I think there was a time when the tall trees had fallen, and you were left with some of the young saplings doing their best. They were easily shook up – and then we had someone undermining [them] and they did not have the confidence in their own [ability] – they were waiting for permission and they didn't get it and they were undermined...[In the] late 80s and early 90s there was a destructiveness in some nurses who moved into management – they actually actively...wanted to have it all - and so in some ways they ... became all things to all people and...sometimes used their knowledge of nursing against nurses. In fact from a nursing leadership position, I was often fearful of the nurse who was the manager because in fact she undermined [many things] from a lack of contemporary [nursing] knowledge.

(Peach, 2:1 – 2:2)

Individual nurses as drivers have been and will continue to be influential and lead progress in the future. Sometimes, however, individuals sought to work with and alongside others in small groups. As drivers they chose a variety of ways to influence others, as unless others can be involved, an idea is likely to come to very little. The need for a critical mass to enable ideas to be actioned was recognised by many nurses and a variety of means of communication was used to enrol their colleagues. The nurse drivers called groups together for meetings, they travelled to different parts of the country to speak to key nurse colleagues and to those completing post graduate work studying in Universities or at the Polytechnics. They wrote reports and made impassioned speeches, which they sought to have published in the nursing literature of the day, they brought out to New Zealand nurse experts from other countries to support their cause. They acted as mentors and role models where appropriate

demonstrating the concepts they believed in, and moved things forward – they got things done. Organisations as drivers recruited members, marketed themselves, they developed magazines, journals and newsletters, and employed staff to fulfil their purpose.

Sometimes these activities were effective while on other occasions no matter how much effort was expended, the time was just not right. While some individuals and groups worked collectively, others chose to work alone or in different ways. Church (1994) draws our attention to the value of a diversity of responses, enhancing our capacity to respond to ever-changing health care challenges.

Small groups or organisations often worked collectively as this was seen as being more effective than working alone, and some writers and participants suggested that women (and nurses) function better as collectives. An example of collective action was the transfer of nursing education to the Tertiary education sector. We saw collective action between the NZNA, in partnership with the Division of Nursing in the Department of Health, the Nursing Council and the School of Advanced Nursing Studies – all focused on bringing about change in nursing education, each group with specific roles to play.

The New Zealand Government through the Department of Health approached the World Health Organisation for the appointment of a short-term consultant “To make recommendations to the Government with regard to the system of nursing education in light of the findings [of the report] (Carpenter, 1971, p.9). The Division of Nursing in the Department of Health was intimately involved in the visit of Dr Helen Carpenter as they sought to ensure that the report fitted with the ideas of the Department at that time. The New Zealand Nurses Association spearheaded ‘Operation Nurse Education’ in 1972 with the New Zealand

Nurses Association President, Margaret Bazley, appealing to nurses to stand up and be counted, writing in a guest editorial in the nursing journal.

Nurses, I am reminded, do not demand. These are hard days in a hard world. Polite requests for change go unnoticed. If we want change in nurses' education we must stand united with one voice and demand it.

(Bazley, 1972, p.3)

She also fostered discussion and support for the proposed changes. The Nursing Council gave its support to the report, and the School of Advanced Nursing Studies ensured that all the students were well aware of the issues and knew the 'Carpenter report' inside out (Lee, 1:7). The only group that was not specifically targeted by the leaders of the day and enrolled to the cause were those Registered Nurses already in current practice who would be particularly affected by the proposed changes. This omission proved to be a serious one as the controversy regarding the new graduates was greatest among those who had not been well informed and who saw the future changes as a personal threat rather than an opportunity for improving clinical practice. The controversy continued for many years and the burden on the teachers and new comprehensive graduates was considerable (personal experience).

In the 1980s collective action between organisations became less common as each group worked towards different agendas to cope with the rapid changes affecting all New Zealanders. The 'driving force' for the profession as a whole became divided as organisational energies were focused more on their own needs sometimes to the detriment of collegiality.

For example the NZNA was coping with the wage freeze 1983-4; the 'Nurses are worth more campaign' 1985; whether to join the New Zealand Council of Trade Unions (NZCTU) in 1986; the separation of NZNU

from NZNA in 1987, alongside contributing to a plethora of reports and policy documents. The State Sector Act in 1988, restructuring of the health service and creation of Area Health Boards in 1989 along with restructuring of NZNA itself - to mention but a few issues. By the end of the decade the Division of Nursing within the Department of Health no longer existed, and the Department itself focused on the first of several restructurings. The Nursing Council was working with individual schools of nursing who were working to establish their role in both undergraduate and postgraduate education and dealing with rapid change and the beginning of a competitive environment in both the education and health sectors. It was then up to individuals and small groups to move the profession forward.

Material from the written and oral texts clearly illustrated that nurses taking charge, nurse drivers as individuals, small groups, or national organisations, all contributed to the energy needed to move the profession forward, sometimes as individual efforts and other times collectively. Many 'little things' as well as the 'big things' enabled progress to be made and movement to be identified. Without driving energy little progress is made. The passion, commitment and energy must come from nurses either individually, in small groups, or in national organisations. In the next section I explore the 'why' question. Why do nurses drive?

Why drive?

In seeking to answer this question, we need to remind ourselves that throughout history people have been driven by causes, they have lived and died for causes above all else in their lives. This was also the case for nurses. While some nurses have devoted their whole lives to nursing, there are many more that have given to nursing much of their time and energy throughout their working career.

International and national history would suggest that some nurses are drivers so they can achieve a clear purpose and vision, others have an approach to life that is positive and they always choose to seek out or take opportunities that come their way. Yet others have a passion, energy, and commitment to nursing that sees them constantly seeking to move forward. The status quo is not an option for these nurses.

In 1960 Elizabeth Orbell stated that

One only has to read the current professional literature which is continually expressing newer and newer changing concepts of nursing to realise we will always be asking 'what is nursing?' This is just as it should be for if we should ever become content and complacent with nursing as it is we would not progress, and progress is vital to the life of any profession.

(Orbell, 1960, p. 7)

To continue to progress individually or as a profession we need nurses with energy and commitment who will assist move nursing forward. It was with this thought in mind and her use of the Nightingale quotation "No system can endure that does not march" that Margretta Styles chose as her 'watchword' for the four year term of her ICN presidency the word 'March', and encouraged nurses worldwide to move forward, to make progress, to make a difference (Styles, 1993, p.112).

While both internal and external factors influenced whether nurses and nursing made progress, it was nurses themselves that really made the difference. The **internal** factors that drove nurses included developing attitudes and beliefs needed to **be** a driving force. They had this energising force that enables them to make decisions, to move forward and get things done. This energy was often linked to a clear purpose and vision for what they saw ahead for nurses and nursing. Nurses who made a difference

read the context through their experience and exposure to factors influencing nursing affairs and saw the need for choices to be made.

Margaret Bazley explained how significant having a vision has been for her as a driver, and the resilience necessary to see the vision through. Most of my readings about those who make things happen either for them or for their organisation refer to the concept of a vision - the big picture of the future that is a motivator.

I realised [when looking back over my childhood and the time at Oakley] the thing that I had developed, certainly by the time that I left Oakley, was a burning vision. That Auckland mental hospital was so terrible in terms of the standard of care and the sort of people it had working in it that the only thing that kept me there was my belief that it could all be different. And I could see that by the time I left there – cos I'd done a lot of reading and thinking and talking with a lot of people that I knew I had a vision of what it could be like. And that I realised that that's the thing that I've probably brought right through my career...I've always had a vision and its always been into the future, and I'm absolutely committed to it and always [there are] a lot of people who want the here and now and are frightened by change...I always do a lot of talking around getting that vision, of knowing where I've got to go, but once I've got it clear...So it's that vision.

(Bazley, 2:5)

Margaret went on to say that the vision is not necessarily your own vision, but it needs to be a vision that you believe in. A vision you can commit to. A vision that underpins the decisions you make and that you can take responsibility for. This was certainly the case for many nurses in New Zealand in the 1960s and 1970s as we dreamt about the future of nursing

education. Margaret refers to that struggle, but always with a clear vision as a signpost.

Nursing education has probably been the biggest one [vision] ever because I worked with that for about 15 years and I often think what battles we had, but they keep on. In this job [as CEO of Social Welfare] they're there. [There are visions] in every job because a lot of those jobs you do are boring. They are actually those visions that provide you with the intellectual stimulus and a lot of excitement...I spend hours working out my strategies you know, and that's problem solving, working out how you actually can do it.

(Bazley, 2:7)

Opportunity has also been mentioned as an important trigger for nurses who make a difference. Opportunities available early in life for some, opportunities that have been grasped because the timing is right, opportunities created by stepping 'outside the box', opportunities taken because of an underlying confidence of a person in their own ability – self belief.

Sometimes what has initiated it [the driving force] has been education, and I have seen people where an educational experience has opened the whole world for them so sometimes opportunity, sometimes education, sometimes a mixture of both. Sometimes through their own initiative, sometimes through being promoted and mentored and encouraged by others. Sometimes success breeds success so that for some of those people as they have achieved they have gone on to do other things where they have achieved too and become driving forces in a particular area like education or whatever.

(Shaw, 2:11)

Nurses who help move individuals or the profession forward see opportunities and rather than feeling overwhelmed by change and uncertainty, these nurses grasp the moment – they see the need for nurses to consider new ways, different options, to take risks, to accept the challenge.

Yvonne Shadbolt clearly saw opportunities for change in the 1970s and took the opportunity to establish the first Comprehensive nursing programme in Auckland at the Auckland Technical Institute. Nan Kinross similarly took the opportunity to establish the Department of Nursing Studies at Massey University. In the 1980s, Lee Mathias moved into general management and broadened her skills. Mia Carroll as a new charge nurse created a new culture in a new hospital, introducing primary nursing as the mode of practice. In the 1990s Sally Shaw took the opportunity to contribute to nursing leadership internationally working as a consultant with ICN.

Several of the USA nurse leaders cited in Schorr and Zimmerman (1988) spoke about the importance of opportunity for them. Kinney, (p.158) commented that as she reflected back on her life, she was “acutely aware that opportunity that opened up to me resulted from me being in the right place at the right time.” Cushing (p.59) subscribed to the principle that “when a unique opportunity comes your way you must act upon it because it may never come your way again.” Davis (p.61) had a motto that has guided her journey through nursing “Seize the opportunity.”

Some nurse leaders have a passion for nursing – nursing is or has been a life long career for them and consumes their lives, so they are out there converting whomever they can to work for the good of the profession.

Dvorak, cited in Schorr and Zimmerman (1988, p. 86) stated that one of her beliefs was that she wanted to make a difference in her life “I wanted the difference I made to be a contribution to others.” An example of a

passion for nursing in New Zealand is highlighted by Jocelyn Peach. She expressed her passion about practice and the opportunity she had in the late 1980s to 'dream a dream and make it happen' - an opportunity that led to more opportunities, and more success. She spoke of this opportunity she had been given to establish a framework for practice – to grasp the moment and use her passion and energy to pull a dream from the past to the present and create and influence the future.

I had been given by Anne Murphy [Chief nurse Auckland Hospital Board] that responsibility of dreaming – dreaming a dream and making it [a framework for practice] happen - and the total authority to do whatever I liked in an eight month period. Being/having that total opportunity – it was just wonderful. That was nursing as a driving force, like I had this dream and it was, how could you help make other people come on board with that dream and then getting so much support, was just – I mean an exceptional opportunity and I was extremely honoured and lucky to be part of that. So you were allowed to drive. The driving force, and I guess what I was trying to do in there was to capture those others who had the same sense of passion about practice.

(Peach, 2:14)

There are however situations where enthusiasm and commitment are present and there is a lot of talking done but very little action. Some of the meetings held in the 1990s to assist the profession move forward are examples of such a 'talk fest'. The 'Vision 2000' conference and some of the consensus conferences called to debate nursing education or advanced nursing practice were disappointing for many participants as there was little consensus, few clear outcomes, and little follow-up.

Were we realistic in our expectations? Can a group of 1 – 200 enthusiastic and committed R.Ns pull together ideas that are clear enough to ensure

action? Again we come back to the importance of those ‘crisp timely’ decisions. We need to learn to strike while the iron is hot so to speak, to capture enthusiasm, and to move forward. Words without action mean nothing at all, and does nothing to enhance the primacy of the nurse. Jocelyn Peach described her frustration with events that led nowhere primarily because of the lack of action that follows.

We are so passionate about our profession and our views that we can't hear each other. That's why I think we sometimes miss out on making things happen. I have to say just one thing here about the recent developments – this thing called the ‘Consensus conferences’ which drive me bananas. Only because, I have no difficulty with us debating, discussing, and reaching an agreement – I think that's just amazing. I love it. What I can't stand is the absolute inertia that follows those things ... We talk ourselves to a standstill and that is not nurses as a driving force, it's nurses as – paralysis by analysis - and I just can't abide it...I think also it is sometimes our fear of making decisions. While we make decisions because it is important, but we also fear it because we don't stand together on things – we don't say we trust you – we don't say OK Joc maybe at this moment in time you are the right person to lead us forward.

(Peach, 2:14)

While nurses who are in charge accept the challenge to move forward, there are sometimes situations where the time, the effort needed, the support required seem overwhelming, and progress comes to a halt – good ideas stall.

External influences also played a part in development of some of the nurses who then became drivers. As previously mentioned nurses visiting New Zealand or New Zealand nurses travelling overseas provided

stimulus and opportunity. It was interesting to briefly explore how this external influence changed over time.

In the 1960s and 1970s nurses brought to New Zealand by a variety of agencies had varying levels of influence as drivers. Such visitors to New Zealand were initially invited by institutions such as the University Grants Committee, or by the Government of the day especially through the international contacts of those working in the Division of Nursing (Helen Carpenter, 1970; Alma Reid, 1965; Margaret Shetland, 1975).

The 1970s also saw the beginning of the influence of the NERF Travelling Scholar where nurses regarded as specialists in their field were brought to New Zealand to travel to several centres and share their expertise with New Zealand nurses with similar interests. The range of topics was extensive including gerontology, mental health, nursing research, nursing theory, inservice education, and the influence on those who attended was sometimes quite profound, increasing commitment to the profession and to professionhood.

As specialisation in practice developed international nursing conferences enabled nurses to share experiences and to learn from each other (for example operating room nurses, and cancer nurse specialists). These opportunities were still few and far between in the 1970s and summaries of the reports or details of how to access the information could still be shared in the nursing journals.

In a similar fashion, nurses from New Zealand who travelled overseas on observation and study tours, came back to New Zealand full of ideas and with a new found energy and purpose, and they sought to enrol other nurses to their particular point of view. New Zealand nurses had always attended the ICN quadrennial congress sometimes in large numbers. In the 1960s and 1970s reports of these meetings and overseas visits were often printed in the *NZNJ* and accessible to nurses throughout the country

(Archdall, 1961; Hollis, 1968; Laws, 1978; Lomas & Brewster, 1976; Orbell, 1965; Selby, 1974:).

The 1980s and 1990s saw New Zealand nurses in large numbers share experiences and extend their knowledge by attending and presenting papers to international conferences all over the globe. The range was enormous and unfortunately the ability to publish or to share reports of these conferences with others was mainly limited to those nurses in contact with the paper presenters. Many nurse visitors also came to New Zealand, particularly through the educational institutions. It was difficult to keep up with the flow of ideas, and international nurse experts came and went with many nurses unaware of their visit. The effect of these visits on the individual nurse or group of nurses was still influential but the effect/response was not as widespread as some of the visits of the past. The expert knowledge available meant nurses could probably spend all their time reading the ideas of their colleagues and still not keep up with what was available. The influence of the Internet was also beginning to be felt as nurses could share their ideas and questions with others all over the world within seconds.

The first content area in this chapter has enabled me to explore the who, the how and the why of nurses taking charge. Nurses as individuals, in small groups, and in organisations working with energy and commitment. It was interesting to note how really significant it was to have a driver – someone willing to commit. As a profession, nurses have many great ideas, we could agree that the idea was worth following through, but unless there was someone willing to act, willing to enrol cajole and energise others, we did not make a difference and effect change. We needed nurses taking charge, in charge of their attitudes, their values, their responses, their destiny – nurses as a driving force.

The next piece of the quilt to construct is the third content area and describes the attitudes and beliefs of nurses taking charge underpinning the ability that enables the primacy of the nurse to be revealed.

Attitudes and beliefs of nurses in charge.

I plan to use this section to showcase some of the participants' descriptions of attitudes and beliefs of a nurse driver. If we are going to make a difference and effect change we need to **be** energisers, to be drivers, so it is important that we should spend time exploring this topic and gaining some new understanding about the attitudes and beliefs of a nurse who was a driving force. The powerful stories provided by the oral history participants highlighted the primacy of the nurse, and I have lifted out of their texts illustrations of the potential for the individual and the profession to be a power for good, to really make a positive difference .

The attitudes and beliefs that the participants associated with a driving force, an energiser, included particular 'triggers' that energised individual nurses or groups of nurses so that they respond and became drivers and 'certain ingredients' that assisted nurses to be a driving force for change in the sense of moving forward. The attitudes and beliefs that enabled the nurse to make a difference and effect change were built on those that were revealed when exploring the source material of the first two themes. Attitudes and beliefs that underpin the importance of effective decision-making, and a developing sense of autonomy and accountability.

The triggers or 'interpretive turn' leading to some nurses becoming drivers included particular experiences that impacted because they occurred at a time when the nurse was particularly receptive to the experience, such as post registration education for the mature student, or opportunities that provided a chance to do something different or in a different way. The ingredients needed to drive included being competent, being open to change, liking a challenge, ability to market ideas and enrol

others, having a sense of excitement and passion as well as having the sense of confidence referred to so often in this study.

In my reading about leadership and change, several writers (internationally and nationally) suggest similar attitudes and several emphasise that 'leadership' in the sense of drivers/energisers can and should be found throughout an organisation (Bamford, 1997; Bennis, 1995; Brosnahan, 1996; Levy, 1998; Peach, 1997; Schorr & Zimmerman, 1988).

Warren Bennis (1995) following a study of leaders in organisations suggested that four basic competencies are necessary to make a difference and effect change. These competencies are vision; communication and alignment; persistence and constancy; focus and empowerment and are similar to attitudes mentioned by the participants as important in moving forward effectively.

Brosnahan, a 1996 Harkness Fellow from New Zealand, writing in the USA about her search for a framework to identify leaders of excellence and what type of person such a leader should be, describes the concept of taking others on a journey of self-fulfilment and collective action. The leader needing to have among other attitudes the energy and drive to persevere and a passion for what she is aiming to achieve, which is infectious.

The following pages reveal the views of some of the New Zealand oral history participants and the USA nurse leaders in relation to nurses as drivers. Their message is very clear, and covers topics including 'certain ingredients' associated with a nurse driver, how we can learn from drivers, the social force of the individual/collective, power, and control, and the influence of particular 'named nurses'.

Sally Shaw and Nan Kinross describe a number of ‘ingredients’ or ‘characteristics’ that you can identify with the nurse who makes things happen. Some of these we have seen before expressed in the attitudes and beliefs associated with the first two theme chapters, while others add a new dimension.

Sally thought there were a number of influences and ‘certain characteristics’ that assist some people to organise and take action. While there were a number of ways people could do this, and opportunities were often waiting to be actioned, there were always some people who preferred to be led.

I think there are certain characteristics in the makeup of people that make some prefer to be drivers – organisers and doers, and others who exert their influence in a different kind of way or prefer to be led. I think peoples’ experiences make a big difference ... Right from early in life, and there is no doubt that negative experiences often breed negative attitudes but then that is totally opposite of somebody like Mandela, and people who can go through enormous adversity and emerge as strong proactive driving forces for change. Sometimes the driving forces [in the sense of external forces] are positive and sometimes they are negative.

(Shaw, 2:10)

This focus on our past experience is important and linked to the powerful impact of socialisation on our attitudes, beliefs, and responses. In the two theme chapters several of the participants referred to the influence of their families, or early experiences as students, and the triggers or the ‘interpretive turn’ that influenced their decision-making or understanding of autonomy and accountability. The impact of negative experiences for some of us needs to be acknowledged and was referred to in some detail

in the last chapter when discussing apathy and the sense of victimisation some nurses feel. External driving forces can have negative impacts if we let them. We could recall the Chinese proverb suggesting that while crisis connotes danger, it also connotes opportunity – the choice is ours.

Looking at the positive attitudes of nurses who effect change and make a difference, Sally suggested that seeing and grasping opportunities as they arose was a significant attitude.

I think that many of the people who have become driving forces in nursing have had opportunities from a fairly young age which either they have grasped for one or other reason, or other people have encouraged them to grasp...People who have made a difference, and then as people take up certain opportunities and get experience from that, then it becomes a flow on effect. More opportunities arise and they are asked to do things, they become more visible.

(Shaw, 2:11)

This described Sally's own experience, being persuaded to complete a nursing degree while overseas in Canada, coming back and being asked to use that experience teaching in the Post Graduate School, getting known within the system, moving into the community health field, being asked to speak nationally to share her ideas with others and eventually being persuaded to seek the position of Chief Nurse within the then Department of Health.

Several of the participants talked about opportunity. Being ready for opportunities as they arose, seeking opportunities during times of change, and just not waiting for things to happen to them. This was supported by several of the USA nurse leaders cited in Schorr and Zimmerman (1988). The grasping of opportunity is enabling, and if the experience gained is positive, as Sally described, it becomes a flow on effect. This positive wa

also linked to the issue of confidence, a concept that has seemed to be mentioned many times as an important attitude. Confidence in making effective decisions, that leads to confidence to be accountable and responsible, the confidence to reflect on the meaning of autonomy in a variety of settings and then the confidence to drive – to move forward.

Nan Kinross discussed ‘certain ingredients’ that nurses needed to be a force for change (in the sense of moving forward). These included enjoying a challenge, marketing your ideas and enrolling others, knowing the system, being creative and able to be excited about what you were doing.

*I think that the first thing is that people need to like a challenge. The first thing you need to be able to do is to **enjoy** a challenge, ...and to encourage other people to think out ways around or over that challenge. And that the challenge stimulates you – it puts your adrenaline up, you really get a buzz out of it. Now if you don’t have an adrenaline rush when you’ve got a challenge – then I don’t really think you’re going to drive or lead anybody anywhere. You’ve also got to think about people who can market the product who can market the ideal, who can talk other people in to doing things, who’ve got political nous, who can in fact go to a meeting and know that you’ve chatted up several members of that meeting before you ever get there – um in other words you’ve got political nous – you’ve got the numbers. You need to know how to use the system...*

Above all I think is a sense of self and excitement – able to be excited for Gods sake and to be excited about your idea – even if you lose you’re excited about it you are energised you feel that here’s something that people ought to listen to.

(Kinross, 2:15-16)

The ‘ingredients’ highlighted by Nan, reflected her experience within both the political system of Government, and the political system of academia. She reminds us about the importance of excitement and challenge. As Margaret Bazley has commented, work for many people is boring, and we need the challenges, the stimulation of strategizing to reach a vision. To be a nurse driver, to move forward, to energise, there needs to be some passion, some commitment to the task. Nan does however remind us of the important step of enrolling others. The excitement of the challenge will be less effective if we haven’t done the hard work of enrolling others to the cause. I often heard nurses complain about an issue and when we discussed what they had done about it, the answer was often ‘nothing’. No commitment, no enrolling others. Without support, challenge and change can be scary. Sometimes however the answer was that the person has done something to effect change, but only once – minimal effort. One letter, one discussion, one small move forward. Without the ‘political nous’ Nan refers to, persistence and resilience, or ‘the numbers’, it is hard to drive – to move forward.

Yvonne Shadbolt supported the concept of nurses as drivers in the sense that they communicate clearly their idea, enrol others, and move on.

They articulate an idea or a direction, persuade others that it is an appropriate way to go, recruit their long term commitment to that idea, and as such drive towards an end.

(Shadbolt, 2:10)

Mia Carroll also emphasised the importance of the driver communicating and enrolling, and used the idea of ‘creating space’ for discussion and debate. A concept Margaret Bazley raised in relation to decision-making. Creating space had different meanings for the two participants, both of which are significant for me. On the one hand Margaret used creating

space in the context of breaking ground, leading the way and ‘making space’ for others to follow. Mia on the other hand used creating space in the sense of making time available - creating space for time to debate and to reflect on issues. Both ideas were interesting in the context of the primacy of the nurse.

Mia also described the need to be willing to move, being enrolled so that you want to move in a particular direction .

*The willingness to move requires that the leadership can articulate the benefits of moving in a particular direction and can make the steps towards moving easy. I think nurses can be a **huge** driving force but aren't. I think we have the potential to be a huge driving force – our education processes - I think how we choose to teach, to learn, to practice, is hugely powerful but it is untapped, unharnessed, unchanneled sometimes. Sometimes it is so disparate because of the ‘tyranny of the urgent’ that it requires leadership to ‘create space’ for it to be galvanised...Creating space for united action to be debated and discussed and put forward means that nurses can be a hugely driving force, but if their vision is only to the first notch, and if the vision is not leveraged to seeing beyond their wee little piece of the world – then it is a very narrow driving force.*

(Carroll, 2:13-2:14)

Creating space for debate permits us to learn from each other especially those who can inspire, who have charisma, who have thought through the issues and can clearly articulate their ideas.

Marie Burgess described the charismatic effect of a nurse, using an example of when she was a student [at SANS] and the effect of Rita McEwan, a leader in psychiatric nursing in New Zealand, who on return from overseas, made a brief visit to the school during the year.

She swept in, in a wonderful trench coat, having just come back from Egypt and rushed into the room and said ‘Hello everybody and who are the psych nurses’? She rushed and made a great fuss of the psych nurses and we thought who is this extraordinary person, so full of life and vim and vigour and just back from Egypt? So here was a New Zealand nurse who had been away doing these wonderful things [acting as a Consultant for WHO] in other places. So you became conscious of New Zealand nurses like Bea [Salmon] who had already done things overseas as a consultant –setting up university programmes and things and there was Rita coming back from WHO. You became conscious of other New Zealand nurses who were playing their part on the international scene.

(Burgess, 2:9)

The symbolism of this description, the vitality, the wonderful trench coat, sweeping into a room, and immediately focusing on Rita’s commitment - the psych nurses, demonstrated the impact an individual made over twenty years before. Marie’s recognition of the reality of a New Zealand nurse creating an impact. Someone who had been a consultant in an exotic foreign land (Egypt). Then the recognition that another New Zealand nurse, Bea Salmon, the Principal of the School, had done that too, and developing a new understanding that nurses could be inspiring leaders.

This understanding that New Zealand nurses could be leaders, could travel and be an example to other nurses, could be role models was a trigger for Marie, and led to her continuing her study, and personally making a difference too. Marie identified the impact of that year with Bea Salmon when she wrote to her some months after the course had finished.

[I remember] just trying to put into words how much that year had meant to me, and how much I appreciated especially in retrospect what, how it had changed me in all sorts of ways.

(Burgess, 1:4)

For some of us who were previously aware of the influence of overseas nurse visitors, it was a really important lesson to learn that New Zealand nurses had ideas too, that they could travel overseas as to assist and inspire nurses in other countries, and be consultants for agencies such as WHO and ICN. Marie described gaining a conscious awareness of the impact of nurses globally, the international idea, initially from nurses who visited New Zealand in the 1960s and 1970s.

They came and gave us new ideas and often extended your thinking ...put things in ways you hadn't heard before and talked about theorists...All strange and wonderful. The other thing I guess it did, even unconsciously, was the fact that it demonstrated that nurses could have this higher level of education and they could be inspiring leaders. They could travel the world and they could write and there they were giving a session in New Zealand that you would maybe be at, or [they were] running a workshop... So you could look at them and think well, – there's somebody who has done all that...well informed, well educated, well respected and do all these things and isn't that great. And its not that we didn't have these people in New Zealand but you tend to take your own people for granted.

(Burgess, 2:8)

The impact of these visitors raised our awareness that they were nurses just like us, they were well educated, and they were inspiring leaders. The impact of role models as examples to aspire to, as major influences on their own development, was described by several of the participants.

Several of the oral history participants recalled nurses, who had influenced, informed and taught them, helping them on their journey, their pathway, understanding the impact of effective decision-making, taking action, and being responsible for those actions.

Elisabeth Lee described recalled the influence of a new Principal Nurse, M.R., in the early 1970s. A New Zealand nurse who had travelled overseas on a study tour and came back wanting to implement her ideas - to be a driver, to contribute her ideas and enrol others to see value in them. This was a very timely visit as the transfer of nursing education to the tertiary education sector meant that the NZRN was going to need to learn to practice in a different way.

M. had had an overseas study experience and came back wanting to introduce primary nursing into the hospital...We used to discuss models and things like that which were totally unusual. She used to come in and I can remember her saying 'I was out gardening and I had this idea'. I remember this quite vividly. She had a piece of paper with a circle on it and had the patient in the middle and all of the things around the outside. I mean these were things – concepts, ways of thinking about things that were quite new and foreign to us at that stage. Maybe not if you had been involved in formal education in the tertiary sector but at that stage we had not been...M. had considerable influence in that place in the development of primary nursing and the development of standards and the use of the nursing process and so forth...She used to talk a lot about what she was trying to do, she was very visible in the hospital.

(Lee, 1:3)

M.R. demonstrated the skills of enrolling her staff to see value in the idea of primary nursing at a crucial time of change. She was visible to the staff, she talked to her staff, and shared her thinking.

The experience of Yvonne Shadbolt with the NERF oral history project, which involved talking with nurses of various eras and generations, reinforced the impact that the 'named nurse' had on individuals. The 'named nurse' in the sense of the nurse whom they remembered and could name as making a difference, who was an influence, because what they were doing was for the benefit of the public.

You recognise the impact that named nurses had on individuals at that time, and the way in which those individuals felt a sense of loyalty and a sense of following. I don't mean blindly following, but believing that this person was working hard for the good of nursing and that it was important to support them. In doing that and underlying that, and I think we don't articulate this enough, is that the good of nursing only occurs when it leads to the good of the person that nursing serves...the public, or the individual client or family. In many respects the ideas live or die only when you demonstrate that in some way, or persuade others that there is in some way an ultimate benefit to be gained, for the only reason that nursing exists is the care of those that they are assisting.

(Shadbolt, 2:11)

Several participants mentioned this concept of nurses and nursing being a force for good, a social force. Mia Carroll and Jocelyn Keith were very clear about the potential of nurses as a collective. Mia explored the idea of nurses as a collective, a social force, a social movement, and a driving force in terms of primary health care

They are a social force who would work with patients in their own homes to heal them and discover what is the benefit of not being healed – and work to create. I mean I think nursing can be a driving force to increase people's capacity to choose. I think nursing can be a driving force therefore by implication to improve the great inequities in social justice.

(Carroll, 2:15–16)

Jocelyn Keith was very clear about nursing (in the sense of the collective) as a power for good, a social force, but not so sure about the individual nurse at the moment.

Nursing is a power for good – it has the capacity to enable people to lead more productive lives and to bring them to more graceful conclusions and that's quite a special place...there's no two ways about it – nursing as a power for good is a driving force inevitably. But even saying that word 'inevitably' I'm feeling disheartened about nurses at the moment, as I think many of us are, because that 'inevitably' depends on a professional workforce - nurses who will stand by their patients, who will be accountable, who will articulate what it is that nursing has to offer, and who will work collaboratively with women's movements and others to advance people's health. To be honest, I'm not seeing it at the moment, and I'm worried whether I've been living a delusion! Where are our educated nurses, and [how] are they making a difference to people's health?

(Keith, 2:10)

While Jocelyn was unclear about the social force for good being demonstrated by the individual at this particular time in our history, Nan Kinross had a different view. She was not so sure about the collective –

nurses as a group making a difference, but very clear about the driving force of individual nurses.

First of all I have to say that I'm not sure that nurses as a group are a driving force very often...I'm thinking now of conferences and so on. There are always in that group people who are indeed not very creative and for whom new things frighten them – who are thinking of ways of putting up walls, and separating themselves from whatever is new and from any problems that come up. Nurses on the whole I think are not very good with conflict for example and the way in which they handle conflict - Now I'm generalising, but many nurses handle conflict, and this includes academic people in academic positions, by passive resistance. They've learned to do that and they've learned to do that in the work situation

(Kinross, 2:14)

The question of the individual in contrast to the profession has been one of the contrasting filters I have used throughout the discussion and analysis of the source material. There are times when the individual is way ahead of the profession, and times when the profession as a whole has a momentum that gathers up the majority of the individuals and they become part of the progress, the move forward. For example the changes in modes of practice in the 1980s, undergraduate degree education in the 1990s. The application of this contrast to the topic of a driving force was very interesting and like many other issues varied over time. I observed the profession as a whole driving the regulation of nursing especially competencies associated with practice, while individuals were taking the lead and wanting to explore in small groups issues like what constitutes 'advanced practice' or 'nurse prescribing'.

Individuals making a difference contrasted with the larger group can apply to the broader society as well as the nursing profession. The lack of a driving force was previously mentioned in relation to opportunities lost by individuals or the collective through apathy – in the sense of inertia, passive resistance, fear, paralysis by analysis, and a perceived gap in leadership. I was most interested to hear a television commentator reporting on a Colmar-Brunton poll discussing issues relevant to the November 1999 general elections (Holmes, 1999). The number one issue identified by those polled was ‘lack of leadership’. Lack of political leaders with vision, a sense of ‘get up and go’ and a willingness to be accountable. So it is certainly not an issue that applies only to nursing.

The last comment on the attitudes and beliefs of nurses as drivers is related to the concepts of power and control. Mia Carroll described her view of the struggle the profession has with concepts of power and control and the unwillingness of some to accept that there are different perspectives along the way. We are back to the discussion of choices, of accepting or resisting change, as individuals and as the profession as a whole.

I think nurses are capable of either sustaining or preventing change. I think the willingness to move requires that the leadership can articulate the benefits of moving in a particular direction and can make the steps towards moving easy...I think the partisan nature of nursing in New Zealand...reflects a very immature profession struggling with concepts of power and control and vision...It's around the people they cut off who have a different view and I think we have got some visionaries who've been whittled down. I think some, and I look at to be perfectly frank what's happened between AIT and us at Auckland Hospital...

I know that part of that huge change has been because the two individuals at the top have had a strong commitment to it and a belief in the fact that education and practice have to work together. I think that in a way both organisations have aligned themselves now. Have strengthened that infrastructure so that it is becoming more and more sustainable without those individuals, which is what you'd hope for.

(Carroll, 2:14)

We have the problem of the 'tall poppy' syndrome, we complained about lack of leadership, about apathy, and then when someone gets moving we criticised them and made things difficult. There is a tension associated with this struggle. On the one hand we as a collective want strong leadership. We ask 'where have all the leaders gone?' We want our leaders to be strong, to do more, to be more. On the other hand, if our leaders are too successful, too up front, we cut them down. We appear to want strong leadership, but not too strong. Effective drivers support others working with them and are in turn supported. As several of the oral history participants have stated, you can't effect change thus making a difference all on your own. You can't act without support from your community of interest.

The 1990s were a particularly difficult time for nurses and nursing, as outlined in the nursing context chapter. Jocelyn Peach spoke about the 'struggling time' of the late 1980s early 1990s with the major restructuring in the health sector, in NZNA, and the lack of support for nurses moving into new nursing leadership roles.

Nurses as driving forces were seen as a threat and they either left the profession or (not left the profession) but moved into general management.

[They] felt they knew everything there was to know about nursing so why would you replace the nurse leader, because you didn't need one. Because I know nursing as well as I am a manager. Nurses were a driving force and that's why they were selected to those positions – because they were leaders, they made decisions, they made things happen, they were prepared to be accountable, and nurses went out of [nursing] service in leadership positions into service management in great numbers. But it left a gap again and that's probably why the gap was so noticeable in the late 1980s early 1990s because some of our very strong leaders...were torn between general management responsibilities...we needed nurses in there [in nursing leadership positions].

(Peach, 2:11)

This time of confusion with major changes in nursing leadership was difficult for many in the profession – changing from a time where nurses in positions of authority led and guided the nurses in their organisation to a time when there was an expectation of self-leadership, of professional autonomy. Jocelyn Peach described this period as a time when many of the senior nurses felt the lack of guidance about what to do next. They 'felt the fear but did it anyway' as they worked to move nursing as a collective forward.

There have been times when I've just about developed an ulcer worrying...because there's been no one else to check it out. One thing I learned in those late 1980s early 1990s when the chief nurse were made redundant, (it was a shocking moment) there was nothing in the etiquette books about what to do. You know, we were quite into that [doing the right thing]. Should you have a tea party with the china cups or not, and she [the redundant chief nurse] didn't want it. What do you do! You want to say goodbye

and all that stuff, and in the absence of a plan – you went ahead and you were only five minutes ahead of everybody else. They kept on saying ‘How did she know?’ And it’s only because I’m not sleeping ‘cos I’m so scared about what I’m doing. But no one’s around to tell me this is right or wrong and so you just did. If it felt right and you saw the moments, yeah you just did it. I don’t know – and there were lots of others doing it too. I wasn’t alone in that. But we all felt the fear but did it anyway.

(Peach, 2:9)

The concept of courage (feel the fear and do it anyway) like the concept of opportunity, was a common thread through the previous theme chapters. Drivers need to be risk takers, to give it a go, in order to make progress. Mannock cited in Schorr and Zimmerman (1988, p. 84) had as her motto “Make the decision, take the risk, pay the price” The USA nurse leaders and the New Zealand participants’ comments and stories are characterised by their courage in times of uncertainty, their struggles, learnings along the way, and the wisdom they developed over time. Several of the oral history participants talked about their ‘maturation’, their growing understanding of how to effect change as they became more experienced and reflected and strategised about how to do it.

It is worth noting that these nurses have made a difference over a long period of time, in little ways as well as bigger ways. They made a difference early in their careers, they seized opportunities and took risks. For example as already outlined in this study, Sally Shaw came back to New Zealand with a degree in Nursing and started to share her ideas at the Post Graduate school not long after registration as a nurse; Nan Kinross (under direction) took up a position as a Supervising Matron in Invercargill as a young nurse; Yvonne Shadbolt took the opportunity to establish a new school at AIT; Mia Carroll initiated the ‘Nurses are worth more’ campaign while a new charge nurse; and Margaret Bazley finishing

her Post Graduate studies was appointed to a position as the Matron of a major Psychiatric hospital.

The participants' experiences and accounts made it clear that we could learn the skills about how to contribute effectively. We can start anywhere, anytime, the challenge was always to seize the moment, to have the self-belief and confidence to begin, to take a risk, the opportunity to build the skills and to continue to grow. We can learn how to move forward through the reflections and experiences revealing some of the attitudes and beliefs of nurses in control, nurses taking charge – evidence of the primacy of the nurse.

Insights from nurses who made a difference

As outlined earlier, there are different kinds of drivers, some inspire, and others give us new ideas and extend our thinking. They can make a contribution in their own local area (the little picture), and/or by contributing to the wider nursing scheme of things effect change for the individual nurse as well as for nursing in general (the big picture). In today's environment nurses need to operate at a higher level and drive the market in the sense that we market ourselves with regard to our value and contribution to the health outcomes of New Zealanders. We can create more professional enthusiasm, both recognising and showcasing the significant input and value that nurses have to offer.

The participant accounts that follow showcase examples of nurses in control, nurses making a difference, nurses making progress, from the participant's perspective as well as examples of themselves as drivers. The examples chosen to gain meaning and understanding of the idea of nurses as 'drivers' come from an amazing wealth of nurse stories, and in the **fourth** content area of this square of the quilt they provide us the opportunity to gain further insights about the concept of the primacy of the nurse.

Leading up to and including the 1960s I have used material from Yvonne Shadbolt and Nan Kinross. Yvonne describes nurse drivers from her student days. One form of influence which Yvonne suggested we tend to forget, the kind of driving force that is steady unrelenting and constant, an influence towards some form of excellence of practice that 'moves the machinery just as much as the high profile driver'. She also describes two examples of 'high profile' nurses in the 1960s and early 1970s. Nan Kinross provides a powerful example of the influence of the Director Division of Nursing in the 1950s and 1960s and contrasts that with the driving force demonstrated by a new graduate in the 1980s.

I then move to examples from the 1990s using accounts from Lee Mathias and Jocelyn Peach in a very different environment. Lee described what we need to do to operate at a higher level to drive the 'nurse market' in a period of deregulation and a market economy. Jocelyn provided a personal example of her role as driver in relation to the establishment of the Nurse Executives of New Zealand group, which could have ceased to exist without a driving force to carry the message.

As the first example, Yvonne Shadbolt describes her experience with the kind of driving force that is a steady unrelenting constant driving, an influence towards some form of excellence of practice. A ward sister in her training days exemplified this style.

The ward sister of women's surgical in my training days, Sister W. who was a wonderful nurse...in other words she cared a great deal about the people that occupied the beds in her ward. She was kind and thoughtful and effective and competent and she cared about the students that went through her ward. She worked very hard to see that we were exposed to certain experiences – she watched, guided and helped us achieve those skills in a very thorough

planned way and I just thought this was my ideal of a ward sister and if one day I was ever going to be a ward sister that's the way I'd like to be...Her way was steady unrelenting constant driving – ensuring that students that came through her ward at their various phases gathered whatever skills were expected of them at the time were exposed to whatever experience was available. I mean that was what was amazing about her – was that it was so consistent – I mean day after day after day, changeover after changeover after changeover – she would take the neophyte and take them through. In a relatively small School of Nursing such as Whangarei you went through Sister W's hands in first, second, and third year and so she knew you [your strengths and weaknesses]. That was a kind of driving force that I came to admire. In the sense that her influence towards some form of excellence of practice must have been enormous because it was consistently applied over 20 odd years and lived on in a legacy with the people that she influenced at the time. And I suppose I came to admire that kind of steadiness of purpose. That ability to revisit and revisit and revisit to reach what she thought was a desired standard.

(Shadbolt, 2:11 –13)

Those of us who worked in the 1960s and 1970s remember similar stories. Stories of Ward Sisters/Charge nurses, whose reputation was strong, whom everyone wanted to work alongside whom everyone admired as epitomising all that was best about nursing. These women began our journey, they set standards, and were so effective that they were never forgotten by the students who worked with them. The strength and commitment to student learning – day after day, year after year, reflected a caring attitude to both students and patients. They were the equivalent of the mentors and preceptors of the 1990s.

Yvonne Shadbolt talked of a whole range of people who set standards and demonstrated qualities that she admired. Nurses who were by no means conforming or subservient and this made you realise how unwise it is to generalise about nurses of a particular era. Yvonne gave two further examples of the kind of driver she was talking about who just got on with things over years and years.

Firstly the Matron of the hospital where she was a nurse aid[e] who on the one hand was amazingly liberal with the student learners, but fierce about her concerns for the patients –

She was amazingly liberal I suppose in many respects, but she was fierce about [care of her patients]. You could be stupid do something wrong and be forgiven,, but you could scarcely be forgiven if you were unkind or uncaring or forgetful in terms of one of the patients. I mean – you could do something really quite wrong and you could get your ears seared right off there was no doubt. But she was fierce about any individual who gave less than their best individually to the patients.

(Shadbolt, 2:11-12)

The second example was her first tutor whose influence as a role model meant that important lessons in relation to respect of persons and confidentiality were learned early.

KM. of Whangarei was a wonderful person and well ahead of her time. Many of the principles and practices of teaching that she employed were the kind of textbook things that were given to me when I finally did 'Education' 20 years later at university level. She cared about the students, she nurtured us and supported us and was warm and all of those things – I mean I admired her enormously. I saw her as a very ethical person ... and she was very keen to show us the difference between right and wrong relative to

things like confidentiality, things like respecting peoples differences and all those sorts of things...Those were the sort of influences that came early to me and they are important – very important.

(Shadbolt, 2:12)

Yvonne then provided examples of the high profile driver – the person who could generate support from others to make progress toward an end – in the sense that they can articulate an idea or direction, and persuade others that this is a particular way to go. Yvonne related her experience with two such nurse leaders. The first was Margaret Bazley in her role as President of NZNA.

I was stimulated and thrilled by Margaret Bazley in her role as President of NZNA. I was Chair of the Professional Services Committee, Education Section, and Margaret rattled us to our back teeth. I was really a non-entity and had no weight in the hierarchical sense and we [the committee] were pretty inexperienced. Margaret came into the room and told us we were the experts on nursing education [at the time of the Carpenter report], which certainly shocked us rigid. We didn't feel very expert about anything let alone nursing education. She told us that she expected that we would advise them [the national executive] - we were exhilarated, rattled, and not a little alarmed. If we were the experts – God help us all! But MP. and one or two others [members of the committee] got absolutely fired up by this and I journeyed down to Rotorua where M. lived at the time – several weekends in a row, and we put together this thing called a Manifesto for Nursing Education which I don't think got past the starting gates but we produced it and presented it to Margaret Bazley.

(Shadbolt, 2:14)

Margaret had done just what drivers should do – lit a fire. With just a few words she inspired a group of nurses to commit themselves to a cause, to give their time, experience and energy to a cause. This story from Yvonne illustrates Margaret Bazley's position of having a vision, developing strategies to ensure that vision could be achieved, and creating an environment, creating the space, for others to move forward. She certainly managed to create excitement among the committee. The second example was Marie Hosking, the Principal Tutor of the Auckland Hospital School of Nursing in the 1960s. Marie enrolled those who worked with her (including myself) to be part of the growth of the profession, to be excited about ideas, and to feel we had something to contribute.

[Marie Hosking] was a highly admirable woman, and in the sense that we're getting to what drives, she was on the Nursing Council and on the Executive of the NZNA. And she would come back [from meetings in Wellington] and say as you well remember... 'between these four walls' and she would make us believe that we had our fingers on the heartbeat of the nation. When I think about it – how she told us so much but never betrayed anything that ought not to have been told - all 'between these four walls' and we thrilled at it... And we were exposed to current ideas and directions in a way that probably few other nurses were throughout the country.

(Shadbolt, 2:16)

We can easily underestimate the impact of such role models. Nurses whose names are not recorded in lights in many places, but people remember them. Nurses that have not had books written about them but none the less they made a great impact on many nurses through out New Zealand. Nurse educators in the 1960s were so important in providing direction for the profession as a whole and acting as stimuli to individual nurses. With the New Zealand Post Graduate School, based in Wellington,

the only opportunity for post registration education for the R.N. and very little access to overseas texts and journals, the question of how these nurses made their decisions, and accepted responsibility and accountability was crucial for the development of the profession as a whole. I remember very well the excitement I felt working with Marie Hosking, and how exposure to documents and reports was both challenging and stimulating. Yvonne told another account of such an opportunity provided by Marie that led to Yvonne becoming self-driven, and internally motivated about nursing.

It was she [Marie Hosking] who insisted that we read the WHO Fifth report [WHO Expert Committee on Nursing – fifth report 1966]. Now for me that was a galvanising point in how I began to think about nursing education because I was sufficiently analytical at that time to ask myself, (because at that time as you know that report was written in a series of general statements that are not directed to a particular country, culture, system or whatever), to ask myself if this was transplanted here [to New Zealand] what would it look like and being quite shaken [by the implications].

(Shadbolt, 2:16)

How Yvonne became and remained motivated about nursing, is a common position for many of the participants. It often took just a small trigger once the person was receptive to ideas, opportunity, and choice, to make a lifetime commitment to become a nurse that can make things happen. Yvonne describes how ‘my engine was continually primed by others’.

When I was seized with an idea, my engine was continually primed by others – Margaret Bazley, Enyth Holdgate [next president of NZNA] and all of those people...and I thought as one does that I had discovered this sparkling new idea...

But other people had it too - not necessarily in the same form but there were sufficient people – a driving force comes out of that – enough people are seized with the concept and possible changes...So I guess in a sense something triggers – you are surrounded by people who drive and you become driven yourself when you see something – a goal worth achieving.

(Shadbolt, 2:16–17)

From this account of everyday role models, and high profile drivers, the importance of an individual nurse as a motivator, able to plant the seed in the receptive mind, the primacy of the nurse is again revealed.

As part of the sifting of the source material through the contrasting layers I have chosen to showcase two opposite portraits of nurses as drivers in the next example. One from a position of positional power, and the second from a position of personal self-confidence. Nan Kinross provided these very different examples. The first from the 1950s and 1960s, was Flora Cameron in her powerful position as Director Division of Nursing. The second, a young ‘inexperienced’ new graduate, in the mid 1980s. In the first example Nan described her relationship with Flora Cameron who used her ‘positional power’ to influence Nan’s career.

Flora, with whom I fought up hill and down dale, but with whom I had really a very good relationship, now she was somebody who evoked either hatred or I don’t know – support. Well she did evoke support. There is no doubt at all that she was energised, she was interested, electric, and she was a driver – there was no doubt at all.

(Kinross, 2:16)

The influence on Nan’s career began when she was quite young as a student at the New Zealand Post Graduate School in the 1950s. Nan had

begun study towards a degree before she started training as a nurse and wanted to pick this up again.

In 1956 I wanted to continue a BA degree [while at the Post Graduate School in Wellington] They were not as enlightened as sometime later, because Flora refused permission for me to take one subject at Victoria during that time...Flora was an enormous power as Mary Lambie had been before her and what she said went.

(Kinross, 1:4)

As an anecdote to illustrate the power of the Director Division of nursing, Nan describes the situation when she worked as a tutor in the Christchurch school of nursing and there was a vacancy in the Department of Health.

I was very interested and I remember I was interviewed by the Director General of Health and [I] indicated that I would like to come and occupy that position. I don't know where Flora was at this time. Audrey [Orbell] definitely was Acting Director that I do recall and Flora came back into the scene. There was at that stage going in Southland a job for Supervising Matron of Southland so Flora rang me up and told me I had to apply for it, and I said well, I thought I was coming to the Department. And I always remember this was on a payphone at the nurses home at Christchurch – in my lunch hour I think I got this phone call so she told me that I wouldn't get that job. Over her dead body would I ever get that job and I was not at that stage mature enough to go into the department. I recall that she wanted me down as a Supervising Matron. And so I was very angry and I can remember going to M C. and really really just being so angry. M. tried to intercede but didn't get anywhere – probably got her ear chewed I would think.

So I did apply for that job in Southland [and was appointed]...The sequel was in 1965. I was part of the NZ delegation to ICN...I always remember that Flora asked me back to her room at the hotel and we shared a bottle of whisky sitting on her bed. She said to me I thought you would never forgive me for what I did to you, and I said well I nearly didn't but by that time of course I had forgiven her long ago. I said to her I think you were quite right. I did need that experience and it stood me in good stead ever since. That illustrates the power of the position at that time.

(Kinross, 2:4)

In the second example, Nan described how she had been at a conference and heard a presentation by a young inexperienced new graduate that was brilliant. She had an idea, put her point of view in a persuasive creative way, and was not afraid to be herself.

*You need to know how to use the system, or need to have some experience of the system although you can be like S... the first time I ever heard her on a platform. She was very young – a staff nurse, and she had a series of very irreverent over heads...The first time I ever saw S - you could **tell** she was sure of herself, she could play with an audience, she knew how to do this I think she's had some ups and downs sure, but I will always remember that session. She was brilliant now that's what I mean - she marketed the product, she wasn't afraid to use something very creative she wasn't afraid to be herself and I suppose that if you're going to do these things you really can't be worried about what other people think.*

(Kinross, 2:15)

These two examples clarify one of the points lifted from the data about nurses as drivers. While nurses in positions of authority can be, and

indeed **should** be drivers, in reality **any** nurse can be a driver, given the right attitudes and beliefs.

Examples from the 1990s use accounts from Lee Mathias and Jocelyn Peach in a very different environment. Lee Mathias explored the need for the profession as a whole to be more active, to have a more external focus. With her strong management background Lee was interested in our lack of understanding of the role we need to take especially in the market for the nursing workforce. She suggested that as a profession we need to operate at a higher level, and drive the market in the sense that we market ourselves with regard to the contribution we can make to the health outcomes of New Zealanders. She used an example from her own experience to clarify the point she was making.

Unless we're out there driving the market – unless I'm out there in the rural Eastern Bay of Plenty saying – we need nurse practitioners here and this is the level we want them to operate at and so forth. Going off to the Polytech in Rotorua and saying it needs to be at this level – give me a programme at this level. Where we fall down I think was that in our driving we tried to drive internally. We knew what was right for nurses, we knew we were capable of operating at a much higher level and all the rest of it, but we forgot that there is actually a market out there for our skills. We didn't work hard enough to change the market. So it is only as that first wave – the first wave of people like me have come through and have had a better influence on that market have we been able to actually link the two together more closely [market need and the skills of the nurse].

(Mathias, 2:10)

I absolutely agree with Lee. It is very easy for us to be rather naïve about how others see us, about the value of nurses and nursing to the

community. I recall my first exposure to some nurses new to the contract negotiation process. They were stunned to hear that employers wouldn't just say 'yes – have what you claim because you're such worthy valuable people'. It seemed to the nurses that everyone must value them and know their worth. The importance of us being articulate about nursing is demonstrated so well by Norma Lang an American nurse as she talks about the importance of making the value of nursing more explicit in relation to the ICN International Classification of Nursing project (ICNP). "If we cannot name it, we cannot control it, finance it, research it, teach it, or put it into public policy"(Clark & Lang, 1992, p.109).

Lee also talked about the need for nurses to work more collectively led by the Professional Association [NZNO] She believed NZNO was not as influential as it should be in facilitating the profession as a driving force. She recalled how in the 1980s we used to have hundreds of nurses coming together to talk about issues of the day.

A lot of those issues were straight nursing issues – many of them were not the political – wages or whatever. I think that to a certain extent the Professional Association is not as influential as it should be. It should be much more influential in driving that, because nurses are still team players – not a lot of individuals. And until we start getting a big group of nurse practitioners who are functioning as individuals we won't see that change and so therefore the professional groups have to do the driving of that. The nurse leaders and individuals get a bit lost. I mean I get very disappointed when I see bright young sparks, rising stars, and they just get cut down because of very petty things. We're not as a group as sophisticated as we could be in terms of encouraging our young – our tall poppies.

(Mathias, 2:10)

In discussing the role of NZNO with colleagues it is interesting to explore our perceptions of what NZNO could, or should, be doing. The nurse members are NZNO, and must take some responsibility, some action if we perceive the focus is astray.

Using NZNO as an example, we can explore many ways to make a contribution including the following possibilities. An individual from outside the organisation could make contact and challenge an opinion or a decision. An individual inside the organisation could also challenge but is more likely to connect with others with similar concerns – to form a small group and work for change. A small group could similarly challenge from outside the organisation or participate within the organisation to effect change. What stood out with nurses that made a difference was that they **chose to act**. They acted as individuals, they created a group, or worked within an organisation as a whole to help strengthen the organisation - a response was made. Non drivers on the other hand did nothing. They may have talked and moaned but there was no active response either as an individual, within a group, or within an organisation. Nurses who make a difference make a response – they act. Jocelyn Peach provided a perspective as an individual, with a personal example of her role as driver in relation to the establishment of the Nurse Executives of New Zealand, which could have ceased to exist without a driving force to carry the message. She outlined the context of the time, the stress of uncertainty, and again the roles of those who made things happen, having the courage to make decisions and to follow through.

We [the health service] moved from being Area Health Boards to Crown Health Enterprises. It was probably 1993 when the Nurse Executives – the Chief nurses of the day were a changing group, very much an evolving group.

Every meeting you went to, a different person had lost their job or had different titles and the group sort of almost became paralysed in the sense that 'Oh God' it could be me next. Talk about defining moments. So when amidst that sort of sense should we just let this thing die, I decided that we weren't because in fact if our values were important in terms of leadership then there needed to be leadership. So I took it upon myself yet again to lead the group through a strategic planning exercise. Now education has always been a very important part of my leadership and I've worked and studied and worked at the same time but always found that I could apply everything I've learned. I'd just done two strategic planning papers so felt able to speak to the 'kuia' of nursing who were much more experienced than I was and...I led them through an exercise and presented them with a strategic plan and led the discussion on commitment to that plan. Then we just made the Nurse Executives. I read the literature, consulted internationally with the Nurse Executives of America and just basically we established ourselves in the absence of leadership at the service level.

(Peach, 2:14)

Having taken the necessary steps, enrolled others to join her, and established the group, Jocelyn provided an example of the kind of support and encouragement provided for new nurse leaders, illustrating a commitment to the profession and to individual nurses.

We felt – I felt it was my moral duty to the profession and to the leaders of the future to establish a process for support and development and sharing...We could see the writing on the wall...basically the people resigned, retired. Within the group I took on a number of portfolios and then eventually became the secretary treasurer and have been that for four – five years.

In the process I made sure that – whenever I knew there was a gap in leadership, Otago and other places - I made sure that I made contacts within that – to offer support to whatever networks nurse were forming - and say I'm available if you need anything, we can share anything. It wasn't always taken up but at least they knew there was a forum and then making sure that as soon as new people were formed to set in place a mentorship process and communication process and supported where people felt they needed it.

(Peach, 2:14 –15)

The insights provided by the participants who themselves have each made a difference were not about drivers with power, or position. The insights were all about the journey – about how they learned to contribute through their attitudes and beliefs and by being motivated by others as they were exposed to others knowledge and experience. Nurse drivers were everywhere, high profile drivers who inspired and lead, and 'everyday' drivers who year after year contributed to the growth of the profession by their commitment to nurses and nursing.

Concluding remarks.

Understanding the centrality of decision-making and the significance of autonomy and accountability for nurses in this period in New Zealand, it was interesting to now consider the wealth of material related to the significance of a driving force in the context of the primacy of the nurse. This for me is a key chapter, the third square on the surface of the quilt, where the primacy of the nurse in New Zealand 1960s-1990s is made explicit. The idea – the importance of a driving force is one of **action** – primacy of the nurse is all about action. Throughout this thesis I have been exploring the attitudes and beliefs that led to certain responses, ranging from those attitudes and beliefs associated with apathy – where no

progress was made – to active responsiveness where nursing moved forward as a profession.

Over the four decades there were clear examples of changing attitudes and beliefs, examples of when individuals, small groups or organisations were energised and made a real difference (e.g. establishing the ‘C. L. Bailey Trust’, the ‘Nurses are worth more’ campaign); and examples of when individuals, small groups or organisations were apathetic, failed to have a clear vision, or failed to be well prepared (e.g. preparing the profession for major educational change in the 1970s, or managing the change to general management in the health sector in the 1980s). There were times when individuals were most active, and the profession as a whole was apathetic; times when the profession led from the front seeking to enrol an apathetic membership; times when small groups provided a trigger and led the profession forward.

As the texts and the oral history participants made clear, these four decades were not always cohesive times, but when there was an active response underpinned by positive attitudes and beliefs, the profession moved forward, made a difference, and demonstrated clearly the primacy of the nurse. The concept of nurses as drivers reflects this concept of primacy very well – drivers were people who took action, who were energised so they were actively responsive to the context. This study supports the need for attitudes and beliefs that underpin active responsiveness if we are to continue to develop and maintain the primacy of the nurse.

The oral and written texts revealed that nurses as drivers saw what needed to be done, they had a clear vision and purpose, and they understood that actively responding to changing contexts was important for the individual and the profession as a whole. The oral history participants were clear that we needed to acknowledge change and to seize the opportunities when

they arose - to respond to change, to create change, to give nursing the best direction for professional growth. The written and oral texts also supported the idea that having made effective decisions and clearly accepted responsibility and accountability for those decisions nurses as drivers felt free to act, were ready to act, and made things happen. They were risk takers, they did things in times of change that were different, and they took the lead – supporting the concept of primacy of the nurse.

The oral history participants recounted wonderful stories of nurses making a difference – stories of when they made a difference themselves, as well as stories of other nurses they remembered who were energised and who energised others. They also spoke of setting an example and role modelling the ‘how’. These nurses made a difference in ‘big’ ways – like the NZNA strategy of ‘Operation Nurse Education’; or they made a difference in ‘little ways’ like teaching students about the concept of accountability. The participants were energised to develop themselves professionally as well as helping the profession to grow.

A helpful revelation from the oral history participants was that they recognised in talking about ‘how’ they responded, that you could learn to bring about change, to be a driver, at any time in your career. If the participants are typical of nurses in the period who offered leadership it is plausible to suggest that one success could lead to further success. It is plausible to suggest that confidence could develop over time and build further as more tasks/goals were successfully achieved. A big insight from the participants was the sense of developing and maturing skills associated with how they made a difference and that we could contribute and demonstrate the primacy of the nurse with big issues as well as small issues, as individuals, or in small groups, or organisations.

Nursings’ past in New Zealand over the period 1960s–1990s clearly demonstrated that it was pivotally important to the profession that we had

some people out there leading the way. The written and oral texts revealed how they did this. Underpinning the action, the responsiveness, was the belief that 'I wanted to make a difference', and the vision of what that difference might be. The stories of the participants and the USA nurse leaders revealed nurses who made a difference in nearly all areas of practice. Making a difference in nursing education, nursing management, clinical practice in a diversity of settings, nursing regulation, and nursing research. These nurses had the courage and the confidence to take risks, the educational preparation, and experience to seize opportunities; they were in the right place at the right time. We can recognise from the written texts that New Zealand nurses attitudes and beliefs as energisers, as nurses who effected change by being actively responsive to the issues of the day are very similar to nurses worldwide.

The oral history participants saw, with a wider vision than many in the profession, what the future of nursing could be. They could see from their present position how things had been in the past, how they were personally positioned in the present, and what the future possibilities might be (pulling the past through to the present to inform the future). They could put into action things that could bring about that envisioned future, such as changing modes of clinical practice, creating a new education curriculum, leading a team opening up a new unit in a brand new hospital, introducing support structures such as orientation programmes, mentorship, and professional supervision.

Part of the benefit of the hermeneutic inquiry process has been delving into these experiences, to gain a sense of understanding of the motives and actions of drivers over the four decades – the 'why' and the 'how', because the official records of events did not necessarily reveal this explicitly. Working through the written and oral texts I felt a sense of pride in the confident leadership, the primacy, shown over these four decades in many areas of nursing, and I was humbled by the effort that

went into some of the struggles nurses went through as they sought to respond to, or create change.

This theme 'nurses as a driving force' is pivotal because it allows us to see not only whom the drivers were (individuals, small groups, and organisations) but also it enables us to see how those people drove. Sometimes they worked individually, but mostly they needed to work collectively, with other individuals, in small groups or as part of an organisation to bring about change. We can learn from them and deepen our understanding of what happened, when it happened, and what is needed to move forward, and we can explore the 'why' and the 'how' they took the actions they did.

The written and oral texts informed us about the reasons 'why' these nurses were energised. These reasons included having a vision of how things could be; wanting things to be better for nursing; wanting the profession to grow. As individuals they wanted to be a good teacher, a good psych nurse, a good charge nurse. How they used their energy to effect change included seizing opportunities, taking risks, creating space for others, and enrolling others. Many of the oral history participants acknowledged that if you wanted to make a difference - to be a driver moving things forward - you needed to have support, you couldn't do it all on your own. While you could be the very best nurse providing care for your patients, if you actually wanted to raise the standards of nursing in your unit, you needed to have the rest of the nurses agree that that was a worthwhile goal to work for and to support you. Enrolling others to contribute to making a difference was a very worthwhile strategy. This often involved rallying for support, writing hard hitting comment, speaking passionately about an issue at meetings, and cajoling groups of nurses up and down the country. To enrol others to make a difference and effect change, drivers needed to be committed, to be passionate. We can also note that attitudes and beliefs could be infectious, passed on to others.

Participants and international commentators spoke of their addiction to nursing, their love of nursing, their wish to pass on the mantle that was related to passion, commitment, seizing the moment, being willing to make choices and having enough courage to take risks and just do it.

One other strategy the participants mentioned, highlighted that as change takes place over a long period of time – as evidenced by the fifty years it took for nursing education to be introduced into a university setting from those first serious murmurings in the 1920s – we need to learn about the importance of persistence. Persisting and being resilient when barriers seem to be in place. The participants demonstrated their primacy in such situations by discussing how they found different ways around a problem. It might not have been the right time or the right place initially but a resilient attitude often ensured a way could be found eventually, even if it took years.

The enormous strength and potential of the nurse and nursing – the unharnessed, unchanneled potential for both individuals and the profession to showcase the primacy of the nurse is revealed in this chapter. Where nurses and /or nursing made gains it was because we were clear about the purpose driving our actions and the vision or ‘helicopter view’ of the outcomes and we were able to persuade or enrol others to see value in the outcomes. Where nurses individually and collectively made gains it was because of our attitude and beliefs. When we were positive, open to change and challenge, we made a difference. When we were passionate and committed to a cause and had the energy to persevere, we made a difference.

Where nurses have not made gains it was not because outside forces and influences did not let us or did not support us. Where we have not made gains it is because **we** didn’t move, **we** didn’t have the energy or

commitment, **we** were not clear about our purpose, **we** were not actively responsive to the context of the time.

It is clear to me that nurses who make a difference by contributing and effecting change, can be found everywhere. Our task individually and collectively is to find ways to encourage, teach, and support individuals and the profession so nurses can reach their potential in all areas of the health sector, demonstrating the primacy of the nurse.

Chapter Seven: Creating a nursing future

Nurses either give shape to their future or have the future shaped for them by default.

(Christman, 1978, p.2)

Referring back to the intention of this thesis, my interest was in understanding the possible factors influencing the practice and beliefs of the New Zealand R.N over time. The content of the previous chapters has highlighted that it is nurses themselves who make the difference, illustrating the primacy of the nurse during the 1960s-1990s. The importance of attitudes, beliefs and responses of nurses is inherent in this primacy. Building on this knowledge I now explore the subject of this final theme chapter 'Creating a nursing future'.

Grasping that primacy is the essence of making a difference and effecting change, and that understanding the 'how' of primacy could assist the profession create a nursing future, this chapter is about drawing on the wisdom of the participants who lived and exercised their primacy as nurses in New Zealand in the four decades 1960s-1990s.

We know that the nursing profession has access to the lessons and legacies of the events and changes over the past four decades, lessons and legacies critical to shaping our future. Understanding past contexts and how primacy worked for the participants, helps us grapple with potential movements of the future so in this exploration we draw on our insights of the 'how' generated from the understanding of the 'what', the 'why' and the 'when' revealed by the previous chapters. While learning from the

written and oral texts throughout this account we can learn particularly from the participants themselves as they reflected on the significance of the 'how' in their lives and the 'how' of the lessons they learned themselves. I draw attention here to the legacies and lessons with a focus on the 'how'.

Preparing for this 'creating the future' chapter, the participants were asked specifically about the lessons they wished to draw to the attention of the profession when either looking at, or preparing for, the future.

Insights into the 'how' are not offered as a checklist but draw on exploring and searching for meaning about the 'how'. The participants lessons and legacies related to their primacy, their proactivity, their actions that helped shape and create the futures in which they had been involved. With hindsight, the participants reflected on what it meant to be involved, to be using primacy in that way, to be actively generating developments, and so it is their sense of what was important and how it worked. Putting into context both what they did and why and how they acted as they did, was more than working as a driving force, it was actively creating their future. This understanding will also help us to extrapolate how nurses might work more effectively at creating their own futures.

In this chapter we turn our attention to the participants' insights about the 'how' of primacy. Ideas and insights about lessons from the past that other nurses could learn to guide and inform their future. Ideas and insights about legacies referring to the participants' personal contributions to nursing and nurses over time that could be revealed through their stories, and experiences.

Individually and collectively we can learn from the participants what they contributed to nursing, how and why they responded in particular ways, and ideas they offer about how to continue to move forward, recognising

that if we really understand the 'how' then we may be in a better position to be able to inform our own future and how we can contribute, whatever direction the future takes us.

We know some of the trends and patterns will continue, but we also know new patterns will emerge, there will be new struggles, new possibilities, new leaders with new visions. We know nursing will go forward and by exploring the past and pulling movements through to the present we could consider how to inform our responses. We could learn from nurses' decision-making over time, from nurses' emerging sense of autonomy and accountability, and nurses' ability to energise themselves and others. Understanding where we have been, what we believed, and why and how we responded in particular ways, could assist us create a future that will ensure we continue to make an effective contribution. Drawing on the wisdom of the participants enables us to understand how with nurses taking charge, the profession can move on over time, and how we can pick up the mantle to move forward and take on any future challenges.

In seeking a way to clearly present the findings of the exploration around 'lessons learned', the participants' experiences will serve as background. These experiences will illustrate some of the lessons we can learn, and utilise the understanding of other participants to reinforce, challenge, or balance a particular perspective.

If we are to continue to contribute to the concept of the primacy of the nurse, we need to understand the processes used by nurses to achieve this outcome.

In exploring the written and oral texts, four content areas emerged that are reflected in the fourth square on the surface of the quactivity quilt. Figure Seven (redrawn on the next page).

Figure Seven:

The first content area is about movement from the past, through the present to the future, that concept that 'nursing as a set of ideas is a living force of continuous existence' mentioned by Hamilton (1993, p.45). The second content area explores lessons we can learn from understanding movement over time. The third content area is an understanding of the legacies offered by the participants, what they did to make a contribution, and how they did it. The fourth area is an exploration of the processes needed to underpin our likely futures, in the sense of identifying how we can ensure continuation of the primacy of the 'new millennium' nurse.

Much of the source material was in response to questions about the participants' thinking. Reflecting about how they made a difference, the lessons they learned, and the legacies they offer as we seek to inform our future. In contrast to the New Zealand voices I used the Schorr and Zimmerman text referred to in the previous chapter, which provided a wonderful opportunity to showcase first-hand attitudes beliefs and responses of another group of nurses as they reflected about their past, the beliefs they developed, and the lessons they learned.

Movement from the past, through the present to the future

Just as nurses have created their past, and are creating the present, so nurses will create the future. Before exploring lessons and legacies identified by the participants, I wish to explore Hamilton's concept of **'Nursing as a set of ideas is a living force of continuous existence'** as I have come to understand her statement. This concept clarifies for me how we can move from the past bringing past insights and observations through to the present, and drawing on the lessons of the past, reveal possibilities for the future.

What constitutes this concept of **'Nursing as a set of ideas'**?

Statements of belief about nursing and the scope of practice were found in many documents and texts as individuals and groups of nurses endeavoured to draw together their values, beliefs and assumptions about nursing with a view to making them explicit. Styles (1982) suggested that this is an important responsibility for us all.

The explication of source – the fundamental origin and boundary for nursing thought and activity – is a lasting and important responsibility for the profession.

(Styles, 1982, p.59)

‘Nursing as a set of ideas is a living force of continuous existence’ has resonance with the oral history texts of the participants in this study. I also feel it has some affinity with demonstrating the changes and movements over the four decades. An illustration of my sense of this concept follows exploring each of the clauses in the statement.

Work on my own statement of belief, a set of ideas about nursing, has been at a personal level, a national level, and an international level. The personal search, which began in the 1960s, is still part of me and will never be finished – it has ‘continuous existence’. The work at a national level involved two significant activities. The first was a collective activity in the mid 1980s as part of an NZNA national committee reviewing nursing education in New Zealand, work which as described in the foreword “explores and confirms the dynamic relationship between the development of nursing practice and the preparation of its practitioners” (NZNA, 1984). The second national activity was in an advisory capacity to the NZNA national executive in the development of an NZNA position paper on social policy. To produce a document “which facilitates decisions through which nursing can consolidate achievements of the past and move with wisdom and courage into its future of service to society”(NZNO, 1993, p.5).

At an international level I have been part of the development of a statement of values underpinning the work of ICN, and in the preparation of the ICN vision for the future (ICN, 1999).

While the context and content may change over time, the intent of the ‘set of ideas’ is remarkably consistent over time - the intent about having a social mandate existing in response to the health needs of society; the intent about the patient, (individual or group), as the central focus of nursing; the intent about the dynamic nature of the contribution nurses and nursing make to health outcomes for the people of New Zealand.

This 'set of ideas' is created through my interpretation and developing understanding of source material, sifting and searching for themes, contrasting the international and national trends, the individual and the profession's perspectives over time. This 'set of ideas' is a response. My response to the attitudes and beliefs I have developed over time, and yet it is still living and changing and will do so in the future.

The next clause in Hamilton's statement is 'nursing as a set of ideas **is a living force**'. What is a living force? For me, 'living' implies nursing is dynamic, moving and growing, while 'force' implies energy, purpose, and action. Nursing is dynamic. "Its boundaries expand in response to changing needs, demands and capacities of society" (NZNA, 1984, p.4). Nursing moves forward, making progress, growing alongside developments in human, social, and medical science. Nursing is energised, nurses with enthusiasm, passion, and commitment provide the energy force. Nursing has a purpose, a mission " Our mission is to lead our societies toward better health"(ICN, 1999, p.99). A 'living force' also implies action – and this is directly relevant to the findings of this study.

If nursing is a 'living force', energised by nurses with enthusiasm, passion and commitment, what actions did we or did we not take, and why did we respond the way we did? Some of the answers were suggested in the first three theme chapters. What lessons from our past about these actions we did or did not take can we use to assist in creating our future?

'Nursing as a set of ideas is a living force of **continuous existence**'. The last clause in this statement is about nursing as 'continuous existence'. Nursing has a past – nursing existed way back and exploring the past allows us to gain meaning and understanding about who we were, and what we did. It has a present – demonstrating continuity and making transparent who we are, and what we do. It also has a future – a future that can be envisioned and created, so we can consider who we could be and

what we could do. Continuous existence also implies change, stirrings of change, proactive change, opportunity and/or danger associated with change, continual improvement (kaisen, kaisen, kaisen).

With this conceptual clarification, the question of the future, exploring the lessons we can learn, and the legacies offered by the participants to inform our future so that we can be part of a 'living force of continuous existence' is addressed in the remainder of this chapter..

Advice about learning from the past has been with us for a long time as suggested by Florence Nightingale in 1885.

In seeking to prevent disasters in the future, it is wise to be guided by as many as possible of the lessons of the past.

(Nightingale, 1885)

Nurses still promoted the idea nearly one hundred years later (Church, 1994; Darling, 1997; Hobbs, 1980).

Lessons we can learn

Hamilton (1996) suggested that we, as nurses, experience nursing from the 'inside out' as much as from the 'outside in'.

Nursing ideas, decisions, and propositions are not impersonal. Nursing's remembered past is human. Because nursing leaders influence and, in some ways, construct nurses' lived experience, the leaders thoughts and achievements create nursing's collective memory. Nurses' historical consciousness, their commission to nurse's remembered past and their willingness to record ideas will shape the story of 20th century nursing.

(Hamilton, 1996, p.5)

The story of 20th century nursing in New Zealand will be the story of the records that are created over time. Thompson (1978) believes that many written sources outlining our past fail to answer the 'how' question. How people felt and thought, how they experienced events. This leaves a void in our awareness of what helped us grow or acted as barriers to progress. The thoughts and achievements of the participants in this study will be part of the record – part of creating our collective memory. The lessons the participants can pass on for our consideration may also help shape the future and ensure the continuation of the primacy of the nurse.

Patricia Donahue, an American nurse academic, proposed that the variables that influence thought, activity and behaviour are the concern of nurses who write about our past because what we think and do influences how we view our past.

Human beings view their past with endless fascination and anticipation. They savour success and achievements, grieve and mourn at failures and injustices, celebrate pageantry, empathise with comparable circumstances, observe recurrent themes, and constantly search for meaning in human experience.

(Donahue, 1992, p.4)

The readers of this study can do just that. Enjoy and savour the success and achievements of the oral history participants or those scholars revealed in the written sources.

Using a series of contrasts, the national/international trends, the big picture/little picture examples, individual/professional perspectives, and time in and between four decades, I sifted through the various sources. I have already illustrated a number of lessons for the individual nurse and the profession. The importance of being strategic, the value of a clear vision and purpose, the need to be a risk taker, the importance of courage and confidence, and the value of just 'making it happen'. We have

examples of how a nurse can move strategically to negotiate with other nurses who have a variety of differing perspectives. (Flora Cameron - working with ICN on the definitions of a nurse and nursing in the 1960s). We have examples of how a nurse with a clear vision and purpose can enrol others to support major change. (Margaret Bazley - as President of NZNA, driving the activities associated with 'Operation Nurse Education', and beginning the transfer of nursing education from the hospital apprentice programmes to the Tertiary education sector in 1971). We have examples of how a nurse who is clear about what needs to be done, can take risks, and move forward in a climate of major change with very few boundaries and guiding principles. (Yvonne Shadbolt - taking a leadership role in the creation of a new Department of Nursing pilot programme in the tertiary education sector – at the Auckland polytechnic in 1975). We have examples of how a nurse needs courage and a strong sense of what really needs to be done in spite of resistance and lack of support from others. (Sally Shaw, working to assist the profession and nurse leaders in New Zealand work with and manage major change in Health Sector restructuring in the 1980s). We have examples of how a nurse who believes in the need to get a job done is willing to 'take charge' and make it happen. (Jocelyn Peach, in the creation of the Nurse Executives of New Zealand in the 1990s).

The thesis themes also provided us with evidence of how the profession has moved on. The nursing profession can learn from these themes the importance of decision-making, why making effective decisions is important, and the need to debate and develop an understanding and the concept of autonomy while being willing to be accountable for nursing decisions. Most importantly of all we can learn that if we seize the moment, the opportunity, and recognise that the potential exists for all of us to 'lead' and 'drive' in our own area of nursing, then the profession can be transformed and nurses in New Zealand could make a real difference to

the health care of the nation. The future is ours to decide – ours to develop, to design, to drive, and to create.

Lessons over time – how to retain primacy

In response to a question phrased around the idea of what lessons could be learned from the experiences of the participants, several ideas eventuated. Examples showcase the participant's thoughts, reflections, and perceptions, and highlight the 'how', the attitudes and beliefs needed to move on to an effective response.

Sally Shaw built on some of the concepts discussed in the previous section. Sally began to present papers and run workshops in the 1980s in an effort to prepare both the profession and senior nurse administrators for the changes she could see on the horizon as the Government began to signal health sector restructuring and the introduction of general management. Sally was always positive about change and when asked about lessons we could learn, she spoke mainly about the process of change – the attitudes and responses needed to take the opportunities change provides, rather than resisting change - the need for courage, confidence, taking risks, and of being proactive, rather than negative and reactive.

[We go] back to courage – confidence which helps you to make the decision, to take the opportunity at the time it presents itself - to take the risk – it's being a risk taker...You have to think positively and proactively (Looking at opportunities how you can shape things how you can prepare yourself or prepare others for changes that may come)...Not just be negative and reactive in the sense of facing change by saying this is terrible and that's terrible. You know that my view is that NZNO made a mistake with that, not all the time, but by trying to defend a way that wasn't...helping the

nurses prepare for the future so I think that would be one lesson.

(Shaw, 2:19)

Sally's work internationally with ICN has illustrated for her that all over the world nurses needed to be aware of the negative effect of apathy, and how being reactive and negative rather than proactive could affect our credibility. In the 1990s the importance of preparing nurses to cope with change, to be proactive and look for the opportunity change may bring was still an important lesson not just for nurses in New Zealand, but internationally too.

If nurses do not seek to contribute in a positive way we will not be asked to participate and our credibility as a profession could be questioned. Establishing credibility at the decision-making table so we can participate in policy direction and planning was a critical lesson for us all.

The importance of [being proactive in preparing for the future] I see over and over the world where people are negative and reactive. They tend to be apathetic but what is most important is that people don't listen to them they don't establish a credibility and people will not invite them to the table. If people are just going to hit people over the head then they'll be kicked out of the room next time round – so the importance of that – I think that's critical.

(Shaw, 2:19)

Sally commented further on the importance of credibility for nursing by being more strategic and better prepared with our arguments. Being able to strategize and being well prepared applied to both the individual and the profession as a whole in Sally's experience. I concur, I have certainly seen nurses let the profession and themselves down by emotional approaches to outcomes rather than a well-planned and developed argument. While this may have worked in the past, (and I have seen evidence that this was indeed the case) such approaches are ineffective

now, and nurses need to understand and communicate in the language of the CEO, the funder, the provider, the politician, and the policy makers to be effective. Establishing credibility is essential.

Nursing has to learn to separate the emotional from the professional. They still try strategies...to influence whatever it is based on emotional/personal arguments rather than good situational analysis and factual well prepared arguments that are going to be listened to. So a lot of that is establishing the credibility of nursing, and I think [we need] to constantly work at being credible in our community whether it's the public or the broader health service or whatever, as an association or as an individual leader...working with credibility.

(Shaw, 2:20)

Sally also mentioned the importance of opportunity. Providing opportunity for people to develop their personal skills, with individuals and the profession taking and using opportunities provided by change. To assist nurses to see opportunity as positive, individuals need small successes to gain the confidence to continue to grow and develop. If nurses are knocked back or fail in an endeavour this impacts on their confidence and can lessen their ability to try again.

Many of the participants illustrated through their experiences a commitment to a particular area of nursing or a strategic approach.

Ann Nightingale retained a commitment to midwifery for many years, Anne McDonald persisted with the concept of 'standards'. Yvonne Shadbolt was committed to nursing education over four decades, Jocelyn Keith had a passion for community nursing over the four decades. Commitment is often associated with resilience. Persisting with a theme or goal. Several participants mentioned attitude of being resilient and persistent as important lessons for them. Learning that persistent ongoing

effort brought results. Nan Kinross described the importance of being able to bounce back - the confidence to take the knocks and know that you can still continue along the path you have set.

I think that the ability to bounce back is really pretty important – and it happens and you go right down but you always come up again and to know that you always come up again and so when you’re right down there you can say – well! I know I’m going to come [back] – I know I’ll come up again.

(Kinross, 2:25)

Mia Carroll and Lee Mathias also talked about the importance of persisting with an issue.

I am persistent. I don’t go away easily and I keep wanting to discover new ways of looking at old problems that don’t have solutions really. So I won’t give up.

(Carroll, 2:20)

Having the resilience to hang in there is what I am known for. Change comes very slowly – I think in terms of a generation re health care planning, the need to hang in there and see.

(Mathias, 2:16)

The comment about the need to ‘hang in there and see’, made by Lee Mathias is important as many of our ideas may take time to come to fruition. University education for nurses for example (60 years) and the review of the 1977 Nurses Act (still waiting after promises in the early 1980s). Resilience and/or persistence – finding another way around the barrier are important attitudes if we want to contribute. In my experience too many nurses gave up too quickly, even when an issue was really important to them. Cited in Schorr and Zimmerman (1988) Bessent (the first black nurse in the state of Florida to receive a doctoral degree) talked

about the influence of her grandmother who instilled in her as a child that the word ‘impossible’ wasn’t in her vocabulary.

Over the years, in various circumstances, people have said to me “that hasn’t been done before” or “that isn’t the way things are done”. My reply has always been, “let’s do it then, let’s be the first.”

(Schorr & Zimmerman, 1988, p.24-25)

To help people develop, to provide support so that they do gain in confidence and gain those small successes can be assisted by delegation and succession planning. Sally Shaw described the importance of such action.

The importance of giving people the opportunity to be in situations or have experiences that will help them develop – help them develop confidence and some of the other skills that are essential for effective leadership...We have to be proactive in that. You know there have been some wonderful people emerge in New Zealand – it’s taken time, but I think we could have helped it [more] by good leadership succession planning – and helped that along.

(Shaw, 2:19 – 20)

Like Sally, Jocelyn Peach emphasised the importance of nurses being proactive especially in the area of succession planning and nurturing the young. She identified how in the past this had perhaps not occurred as often as it should have, and the young and inexperienced nurses were sometimes out of their depth, which could have been avoided. Despite this Jocelyn was very optimistic about the potential for the future.

We need to put a strong succession planning and mentorship process in place. It is not hard to do, and you don't have to be threatened by the young coming through. We should be celebrating and embracing them...That is our role as leaders. Many times in the 1980s and 1990s there were the tall trees that took up all the light and didn't nurture the young. And then there was the time of the medium size trees who weren't strong leaders...Trying very hard but out of their depth and then there was [the time] that the [medium size] trees fell and those saplings that were not supported [were] by themselves and now we are coming out the other end with what I think potentially stunning individuals.

(Peach, 2:22)

The last lesson Sally referred to was still linked to the management of change. The need to be flexible, to be aware of constant change, and to keep in touch with the changing context, the changing environment in which nursing exists.

Sally used the example of nursing education to make her point of keeping in touch with the changing context and 'being ready' referring to a perceived growing isolationism within the education system. This is an international trend, and emphasises how we should avoid the tendency to be inward looking, and to be more effective in our global environmental scanning.

I do fear for is what I see as a growing isolation within the nursing education system – of being out of touch with the world around them - whereas they should be in key positions to be help shaping it. So that is a worry.

I guess the lesson from that is to say that just because a change has been institutionalised like in nursing education doesn't mean to say it's not going to change again when the environment changes. [There is] constant change and how are we preparing people to work in that environment... You've got to keep that door open.

(Shaw, 2:21)

Jocelyn Peach, when asked about the lessons nurses could learn from her, focused on the need for us to understand and articulate our reason for being. During the 1990s Jocelyn focused her time and energy, assisting colleagues articulate the contribution nurses and nursing make to the health of New Zealanders, and how we can effect change. Her passion for nursing was obvious. Her work as a mentor, and her positive image for the future supported both individuals and the profession.

When asked about lessons we, as nurses, could learn from her she began with the need to “know why we are there.” The possible danger of assuming that nurses would always have a place in the sun because we were such nice people was a major concern.

The first lesson is if we don't know why we're there, we shouldn't be there. In terms of our practice – sometimes I think we've not been able to articulate our purpose and raison d'être. In that lack of articulation we've assumed that other people knew that there was a place for us, and how dare anyone think there wouldn't be and that arrogance or that complacency has been so damaging.

(Peach, 2:22)

Damage in the sense that complacency might mean that nurses fail to move forward, fail to be a driving force, and just wait for others to make decisions about nursings' place in the scheme of things, reinforcing the importance of taking responsibility for nursing decisions mentioned in the first theme chapter. Nurses have also failed to be really clear about **how**

we effect change. This must alter in the future for us to maximise our potential.

So into the 21st century must come a sense of clarity and purpose about everything we do. While [valuing] the diversity of nurses - doing absolutely everything is possible, nurses can do anything, I almost think we've got to be realistic that there are something's we cannot do and should not do. [We] should focus on those things where we know we have a purpose and make a difference, and not become captivated by the latest little bit of something or other that we think we might become the expert in...It's about being really clear about why we're there and what difference we make.

(Peach, 2:22)

In order to help others know more about the value of nursing, Jocelyn emphasised the importance of how we present ourselves personally and how we present our arguments – the professionalism needed to articulate to others ‘our place in the world’.

It's about presentation – we present to each other in the narrative, the anecdote. We're not strong in the presentation of fact ...There is a sense of professionalism about who we are that shows when you have come of age. [This sense of professionalism] means publishing and research and it means actually researching stuff that people can understand. There are some theses that I read...and I think what on earth is that actually contributing. That could be seen as intellectual arrogance but I also think that if our social responsibility is to articulate our place in this world, then in terms of nursing it's about presentation.

(Peach, 2:23)

Lee Mathias also described the importance of a professional presentation. She believed that individual nurses and the profession as a whole, can let

themselves down by the way they look, their appearance when attending a meeting or making presentation, as well as their lack of confidence and ability to place an argument. She described how she would want to make sure that nurse's confidence was comprehensive.

That [nurse's] confidence was not only in decision-making, but also in their ability to place an argument and their ability to present themselves in a professional manner. Very simply, nurses lose people [other people's interest] because they turn up looking like tuppence worth ... They don't look professional, they don't look as though they are capable of making a [decision] and whether we like it or not, other people will only respond to you in relation to what they see ... The professional role is something that doesn't stop when you walk out the door of the hospital or the workplace - being professional is about [being professional] all the time – all the time.

(Mathias, 2:12)

The need to be strategic, to prepare factual well prepared arguments included being able to be highly skilled in relation to technology in the broadest sense of the word as well as presenting our arguments in a professional way.

Jocelyn Peach and Lee Mathias both talked about the importance of technology for the future, of how we needed to be prepared, positioned and ready for the opportunities and choices.

We need to become highly skilled in the technology of today and the future. Whether it's electronic technology or its about the technology of good project management – systematic thinking, that sort of thinking – freeing our minds up to be thinking laterally.

Not clinging to task, but being clear about what it is...The technology, whether its intellectual or whatever - we must be more au fait with that.

(Peach, 2:23)

Lee Mathias spoke more specifically about the need in the future for competence in computer technology. When teaching R.Ns about management, she promotes the need for computer skills, and expects them to demonstrate increasing competence in electronic technology.

I'd like nurses to become far more technically competent in terms of computers, and the use of technical communication. We are still not at the level we need to be. If we develop the role of the nurse as the key community health practitioner...we need sophisticated skills in electronic communication and to learn not to be scared of them.

(Mathias, 2:14)

A shift from technical skills and technology to focus on personal attitudes and beliefs was what Mia Carroll chose to explore when discussing what others could learn from her. Over the 1980s and 1990s Mia had completed a lot of personal development and explored the impact we could make by just being human – being who we really are. In her position as a Director of Nursing and Midwifery in the 1990s, the importance of support for others through mentorship and preceptor programmes as well as personal supervision has been significant along with her own personal development.

I think that what people can learn from me is that it is OK to be human - that you don't have to have it all sussed, that in fact...fear is often the thing that stops us from being who we truly can be. That victimology is a state of mind - not an actual event...

I think that what they might learn is that to wear your heart on your sleeve is OK. To bring passion to something is just fine. It's only part of what the puzzle needs but it is a fine part to bring and I hope that they learn from me that the sense of yourself is what gives you a place in the world – not who you are or what you do.

(Carroll, 2:19)

While exploring these ideas relating to a sense of self, Mia also talked about how important it was to her to continue to learn and we talked again about how she worked to assist others make decisions and work through the process and make the steps explicit. Mia was always clear that for her it was 'OK' to be vulnerable. She saw this as strength because you keep growing and learning when you acknowledge that you don't have all the answers.

I hope that people can learn from me that I keep learning...to constantly enquire is actually a very empowering thing to do, and that vulnerability is strength not a weakness...I hope that what people value from being around me is that process is as important as content and that processes are the things that we need to measure more. I know I'm teaching this, but the process of how I think and make decisions is not something secret you know. I can actually articulate the cues that help me make a decision.

(Carroll, 2:19)

Processes outlining the thinking of nurses who contribute and make a difference – what was important to them - is explored in the major part of this chapter alongside the need to make such processes explicit. In acknowledging the importance of the willingness to be human – to just be you - Mia linked this to what she believed society wants the ability of nurses as human beings to connect with them and to care about them.

I think that the very basis of our profession – that connection with assessment and skill and diagnosis, that willingness to ‘be’. To ‘be’ is what society does want. I think that’s what patients in homes, and families, and people want. They want a skilled clinician who connects - who bothers to look them in the eye and who cares.

(Carroll, 2:17)

In line with her previous discussion of the importance of autonomy for individuals involving respect and choice, Mia also believed that society wants this carer to be there for them when needed, and to know when to respect the individuals autonomy.

They [society] want to trust that that person [the nurse] will walk with them when they are vulnerable and not take over from them when they are strong, and I think we’re quite capable of doing that.

(Carroll, 2:17)

Communicating effectively was another lesson to consider especially the need to enrol others and to ensure that they could keep pace with you. This is a common consideration that leaders need to make in any field. In my recent work as a consultant in leadership potential, I find that the communication between people is often affected by the inability of the project leader to ensure that others are up to speed with the concepts before moving on. Mia described the effect on others when you are a quick thinker as potentially ‘scary’, but as an ‘eternal optimist’ she described the value of talking and sharing ideas with others.

Mia has always been an inspiring speaker - as an inservice educator, a charge nurse educating her patients and their families, as a nurse teacher in the tertiary sector in the late 1980s and early 1990s, and then as a Director of Nursing. Combined with her optimism about nurses and

nursing, her skills as a speaker can inspire and comfort others. She talked of her love of nursing – her love of being with patients, with families, her love of the discovery of what it is to work in a collaborative team and try to help create more autonomy. She believed that the day that she lost that feeling she would need to leave nursing.

I am an eternal optimist that we can do it. I do see that it is within our hands to change and I know there are all kinds of social constraints but I do see the possible...Why I keep fighting for nursing is because I keep trying to uncover what it is that we do that makes such a hell of a difference, and name that...I know I'm not that good at writing about it, but I talk it endlessly and I get asked to talk endlessly so what I say must have some kind of comfort or solace. And I know people come up to me afterwards and say to me "It was wonderful to hear". Whether that in the everydayness of their lives - they forget to see it is exciting, I don't know. Because I do [see that it is exciting].

(Carroll, 2:20)

Nan Kinross in responding to the question about lessons learned from her experience also focused on personal attitudes. Attitudes such as not being afraid to be yourself, or to take risks, being creative, and being able to bounce back from adversity. In general all the attributes needed to be positive, to seize opportunities, and to make choices essential to the nurse as a driving force. Nan has spent the majority of her nursing life as a teacher and role model for nurses seeking to grow professionally. While Nan spent the 1970s to the 1990s as an academic, this was a time when she endeavoured to foster individual responsibility, decision-making, and creativity.

Nan wanted nurses to be creative in what they chose to do. To learn to avoid being conformists and to value diversity.

Don't be afraid of being creative, of doing things that are unusual...It's very important that people do that. In New Zealand we are far too keen on conformity...Don't be afraid of risks but be sure you've got some counselling...Someone that you can talk to about the risks – preferably someone who is not involved with you personally, but somebody you can talk the risks over with and be confident.

(Kinross, 2:23 -24)

Like Mia, Nan emphasised the importance of having confidence to be yourself, especially in an environment where success is not always celebrated – the New Zealand recreation of knocking down the tall poppies mentioned earlier.

Don't be afraid to be yourself. Don't get upset when people throw 'brickbats' at you which in New Zealand is a national recreation... Be sure that you've got your facts, that you've got evidence and that what you are saying is based on a good base. If it's just intuitive – say it is intuitive...[Like] I was having a shower this morning and I had this brilliant idea and now we're going to investigate.

(Kinross, 2:23)

The ability to clearly state what nursing is all about, has been a constant theme. Over the four decades nurses have been encouraged to question, to debate, to share ideas about nursing so we could be well informed. Hamilton (1996) using the concept of 'nursing as a set of ideas is a living force of continuous existence' proposed that nurses in the future would want to know more than the public records say about nurses' opinions and concerns.

Tomorrow's nurses will ask: What makes nurses great? ...They will want to understand the opinions, thoughts, and concerns that are concealed behind the verbiage of public language. Future nurses will want to know the origins and the descendants of nursing's patterns of existence, thinking and doing. They will want to understand the basis of different habits of thought and even different perspectives of truth.

(Hamilton, 1996, p.5)

The participants in this study have illustrated their willingness to share their opinions thoughts insights and concerns, as they reflected on their lives and explored the attitudes and beliefs underpinning their responses as nurses who have made a difference over time. They clearly articulated the lessons other nurses can learn from them to inform our present and our future.

The participant's reflections and perceptions highlighted the 'how', the ways we can learn to move on to an effective response. How to learn the language of others in the health sector, to focus outside the nursing world as well as inside to establish nursing credibility. The importance of resilience, recognising that change is constant and that obtaining successful outcomes can take time. How to be ready to take the opportunity, to be confident and able to articulate the value of nurses and nursing.

When reading the text by Schorr and Zimmerman, *Making choices, taking chances: Nurse leaders tell their stories* I was struck by the mottoes or sets of beliefs that the USA leaders revealed - a kind of legacy for nurses of the future. I had asked the New Zealand participants about their legacies and the next section explores those responses.

Legacies offered by the participants

When asked a question related to ‘what they might wish to leave behind, or to be remembered for?’ that might assist the nurse of the future, the participants described the attitudes, beliefs and responses they perceived were important for the future from the background of their own experiences over time. Several mentioned perceptions in common with others while some had important individual comment to make as they have diverse views and different priorities and opinions – just like the rest of us. In addition, whom they were as individuals, the positions they held, and the mantle they wore over time influenced their own perception of their personal legacy.

The importance for many of the participants of a commitment to nursing and their visions of how it might be was clearly revealed. They described their attitudes and beliefs over time relating to this commitment. Yvonne Shadbolt talked about the importance to her of wanting nursing to be better than it was, of seeing the potential to advance nurses and nursing.

I don't think there was much doubt that I was highly committed ... to advancing nurses and nursing...I have really cared about what happened. I wanted it to be better than it was. I wanted the people that we cared for to receive better care. I wanted those who cared [the nurses] to be treated better, both in their conditions of employment and how people dealt with one another. That was important to me.

(Shadbolt, 2:18)

When Yvonne was overseas early in her career she realised that she really cared about what was happening to New Zealand nursing and had this idea that she would like to become a teacher.

I had an enduring belief that how you were prepared to nurse made a difference, and so when I came home that's what I intended to do...I presented myself to the Auckland Hospital Board and said I was interested in being a teacher, and that I would like to have experience across the broad range of things at Auckland Hospital so I could refresh myself.

(Shadbolt, 2:14)

Yvonne described her realisation in the 1960s that nursing education as it existed was less and less capable of producing what was required at the time. This realisation was followed by personal exploration through discussion, reading and consideration of international trends and her vision of how teachers could contribute and make a difference crystallised and led to the belief that education was important and was a driving force in itself.

*When [nursing education] became less and less capable of producing what was required at that time...that probably led me [to] the belief that really education **was** important, was a driving force in itself...Where [nursing education] failed to produce, to provide for beginning practitioners, to produce the kind of product necessary that's when change had to occur. I guess from that point on, I did have a vision (not original or apocryphal) but gleaned from discussion, reading, taking aboard thinking from international thinking, and people that talked to you at home etc. [The vision] began to crystallise, and I think that once that had crystallised for me, (I think I had always been a strategic thinker to be quite honest)...I'd set myself a strategy to become a teacher.*

(Shadbolt, 2:20)

This belief that Yvonne wanted nursing to be better than it was, that how you were prepared to nurse made a difference, and that nursing education

was a driving force in itself, led to a long and illustrious career as a nurse educator. This experience was in both hospital schools of nursing and in the tertiary education sector, with influence in the education policy and direction in both NZNA, and the Nursing Council. Yvonne contributed in the field of nursing education over the four decades of this study, as a leader, a role model, a mentor, a decision-maker, a policy maker, and as a driving force. Her legacy provided support for the 'living force of continuous existence' concept, where over time a belief in the importance of education became a driver, where learning from others nationally and internationally helped crystallise a vision, and strategies and actions were put in place to move nursing education in New Zealand forward.

Margaret Bazley spoke of the importance for her of having a vision in her vignette at the end of the first theme chapter. How by the time she finished her Psychiatric nursing programme in the late 1950s, she had a "burning vision" a belief that psychiatric nursing could be different. Margaret also read widely and talked to a lot of people about her vision of what it could be like. Margaret was sure that being clear about your vision, and knowing the direction to follow, provided both the intellectual stimulus, and strategic direction. Margaret also commented on the importance of action – of making things happen, the concept of a 'living force'. While having a vision was indeed important, without action, without making progress a vision was just a dream. Margaret continued through the 1960s and 1970s as a leader in the field of psychiatric nursing going on to introduce important psychiatric nursing principles in the area of public health nursing.

While having a vision was essential to ensure we knew the direction in which we sought to move along so we continue to exist, an important part of having a vision was enrolling others to be part of the vision. Margaret was very aware of her role in this regard, especially in the broader political arena as the CEO of a large Government department. She

described how she enrolls others in her vision by creating the environment, and clearing the way ahead. Margaret described how a person who has worked with her for many years in different sectors thought that having someone like Margaret out in front, forging ahead made it possible for her to have a lot of freedom. Margaret acknowledged that at the end of the day you can't do the work all by yourself, so creating the space and the environment for others to move ahead became important.

I work on the principle that people like stimulus, work and the excitement. You don't do it yourself, it is really...creating the environment where good people see that there's a lot of excitement and they want to be part of it ... So I provide the environment, I always seem to give them the freedom and to give them the support when they get stuck, to get in there to fight the battles for them...to clear the way, to drive things for them.

(Bazley, 2:10)

We can learn from Yvonne and Margaret about how we need to commit to a vision in order to seek direction. To read widely, to debate and consider others viewpoints to assist envision the way ahead, to enrol others by creating the environment and clearing the way. We can also learn that merely having a vision was not enough. We need to make things happen – to take action, to be a driving force.

Kowalski cited in Schorr and Zimmerman (1988) described her motto as “Act now, and fine-tune later.” She wrote about how many people can have good ideas or feelings about something, “but unless they are willing to act on those ideas they might as well not have had them” (Schorr & Zimmerman, 1988, p. 166).

Lee Mathias wanted nurses to celebrate the fact that they were nurses, to believe in themselves and to be as excited about what they did as she was. Lee continued using her teaching skills in working with R.Ns completing

an Advanced Practice Diploma and spoke with feeling of the lack of enthusiasm in some of the students. We can learn from Lee that supporting and promoting the work of nurse colleagues, and maintaining an enthusiasm and excitement for and about nursing, would be a major contribution to the continuous existence of nursing.

I'd like every nurse to really believe in themselves...I want to get everyone as excited about what they do [as I am] But they are not excited about life! They lead boring lives, don't take risks, no excitement. I tell nurses [in class] that nurses in New Zealand are in the top five percent intellectually (doctors and lawyers in the top three percent) Students are surprised. [I say] I want to stimulate you in ways you have never believed you were going to be stimulated, I haven't lost the challenge...We don't support each other enough – we must promote each other that's what others, the guys, [doctors] do...We must surround ourselves with good people, then our own thing improves...If we are confident then we choose the best and can challenge and stimulate.

(Mathias, 2:17)

While Jocelyn Peach comes from a more recent era, she has worked for nearly two decades in roles where her passion for nursing has been a key driver. Her vision like Lee of other nurses capturing the passion too, has been strong and never faltering. Her work as a nurse leader, role model, mentor, and energiser was important, and she saw her vision become a reality in a number of circumstances. Jocelyn wanted her own passion for nursing to be a legacy for which she was remembered.

What I want to be remembered for is for my total passion for nursing and my ability...to help other nurses capture that passion too. Sometimes it's been hard work because you have had to actually delve deeply, but you know there are people around in our

organisation now who articulate well, evaluate their practice well, and are mentoring others. So I guess that's been important. So for me it's the total passion and that you can make passion a reality. You can make a vision happen. I guess that's an important one.

(Peach, 2:20)

While being committed to nursing and passionate about nursing, making things happen was important for Jocelyn, taking action as a motivator, to ensure that nursing is 'a living force of continuous existence'

I think the legacy I have left [is] despite the fact that you don't have the authority to do things, it has not stopped me from doing what I know needed to happen ... I know you can actually lead as much from the side and behind as you can from the front. In fact it's not about personality leadership - it's about developing a framework ...It will survive because it's the right thing to do.

(Peach, 2:20)

How nurses can contribute in the future is clearly outlined by Jocelyn. If we have a passion for nursing, passion, like other attitudes, can be infectious. We need to learn to make explicit our purpose and vision, and not to wait for permission to do what we know needs to happen, to facilitate the contribution nurses can make to society.

Mia Carroll comes from a similar era to Jocelyn, and in a senior position as a nurse leader in the late 1990s, was very much focused on collaborative practice as outlined in her vignette in the second theme chapter. She spoke of her vision for the future, how she would like the nursing environment to be.

The vision includes things like...dreams of education and practice being entirely collaborative, highly responsive to each other...The vision is of less angst in fighting stupid issues and more synergy...

[Being] mindful of the additional resources that are created through partnership and synergy and the freedom that you feel when you can work like that.

(Carroll, 2:21)

In considering Mia's perspective, as nurses we can enhance our contribution to the future by being more sensitive to the value of supporting each other, and developing partnerships with others – patients, their families, and other health professionals.

Several of the participants identified that their contribution to nurses and nursing included educating others. This was at an individual level for some, as well as for the profession as a whole, over a period of major change. Sally Shaw identified her contribution beginning in the late 1960s early 1970s when there were very few nurses with post registration qualifications in the discipline of nursing.

I did make a contribution very early on...when I came back to NZ with a Bachelor's degree in nursing and there were a handful of people in the country at that particular stage [with nursing degree]...There was at the same time, the stirrings of change and people wanting to move within New Zealand. I was involved in a number of activities both through the NZNA and through my teaching at SANS and other professional activities which combined with that of others did help to initiate some changes at both a personal level for other people and at a collective level in relation to nursing...I was heavily involved in NZNA activities at that time and...it became a time of great involvement in change particularly the nursing education transfer but other things in term of looking at nursing in different ways under Bea's leadership as you will remember at SANS.

(Shaw, 2:13 –14)

As well as contributing at a national level while on the staff of the School of Advanced Nursing Studies, Sally worked with Public Health nurses when she was a Nurse Adviser in the community health section of the Department of Health.

I was in the community health section [of the Department of Health]. We...did a lot in terms of trying to bring different concepts of nursing and nursing education into the Public Health Nursing area. [We] helped to influence things like distance learning modules for people and ran a whole series of workshops for Principal and Supervising PHN's. Now I would like to think that that left a legacy.

(Shaw, 2:14)

Sally also recalled that her contribution as Director Division of Nursing in the Department of Health in the 1980s had a significant impact including involving non-nurses in a nursing review for the first time. This created a legacy and in many areas of nursing working in partnerships with the wider community is now commonplace. It was certainly a process Sally has used ever since especially as an International Nurse Consultant.

We had that review of nursing education under Michael Bassett [the then Minister of Health]...That was a process, which for the first time was opened up to non-nurses and other people in a very open and transparent way and I think that did make a significant impact nationally...It helped because it was so public. It helped to consolidate in the public's eye what [the changes in nursing education] had been and what it was all about and so I think that that was a significant thing. People may not remember it now but that's not the point. It is what happens that creates a legacy that spurs on to other things.

(Shaw, 2:15)

Sally always sought to move things forward, and part of her legacy was to be proactive, to prepare others for change in the sense being a driver, taking action with the vision of ensuring nursing was a 'living force of continuous existence'.

In the 1990s Sally was still working for change, and preparing nurses internationally to contribute to the health services of their countries. Sally contributed by example, by seeking to assist others to understand the changing times as New Zealand and the world moved to embrace global markets and global trends. Sally's legacy included a positive attitude to change, taking opportunities as they arose so that we could continue to make a valuable contribution in the future.

Other participants contributed through their involvement in nursing organisations such as NZNA and the Nursing Council. Marie Burgess for example began her involvement as a student when she was elected President of the NZNA Student Nurses Association in the 1960s, She was President of NZNA in the 1980s, and Registrar and CEO of the Nursing Council in the early 1990s. Marie was one of the younger Presidents of NZNA, and was influential because she did indeed do things a bit differently, which was noticed and commented upon.

[I sought] to lead with people...to listen and take a consensus view of getting decisions made at committee level and so forth and sometimes that is very painstaking...But it's interesting some of the things you're remembered for. I was conscious I suppose being in public health originally – in health education, health promotion – all of those things were part of my nursing psyche...I was President of the Association at the time I was teaching at Tech. So I mean one of the things [I was remembered for] was with regard to introducing health breaks at conference.

Inviting people to come jogging in the morning before conferences and things like that...Sometimes people remind me of that with great humour so I presume I'm remembered...because it stood out because it was...That was trying to set an example.

(Burgess, 2:10)

Marie believed her time as a nurse teacher in the 1970s was another opportunity to effect change.

In teaching I think you have a tremendous influence – there were some people, one or two of the people at the [recent] conference whom I'd taught. It's always really interesting when people come up to you and tell you the things they remember.

(Burgess, 2:10)

This experience was similar to my own, and it is both heartening and sometimes disquieting to be aware of the influence you can have over time, but like Yvonne Shadbolt, if you believe that how a nurse is taught makes a difference, that is indeed a motivating force.

Marie also spoke of the influence of her writing. Her first publication of 'Nursing in New Zealand Society' in 1984 filled a real need for a New Zealand perspective on nursing in contrast with the literature available internationally. (Her other publications are referred to in previous chapters.) As well as using opportunities to influence through teaching, Marie believed that writing leaves something more tangible, a legacy of thinking at a moment in time, and in the future it is likely that we will see much more written by New Zealand nurses.

[I was] very conscious of the writing aspect and I suppose at a stage you think, as you know, it's hard work. Anybody who has written an assignment knows that it's hard work writing...

[I wanted] to actually try and do something that would benefit a wide range of nurses and that might have some lasting and ongoing benefit beyond...teaching. After you've left, they have got something that other people can use in a teaching context or that others can use in the ward...If you're able to do something through writing then at least that states where you are, and that what you believe is important. Other people can pick that up and that's very gratifying if that is found to be useful.

(Burgess, 2:10–11)

In pulling her experience together, Marie would like to be remembered for

trying to continue an ongoing message about education,...demystify the law a bit...and making knowledge more accessible to the nurse...as an author and someone who tried to help the profession in that way.

(Burgess, 2.15–16)

Jocelyn Keith also spoke about writing, but more in terms of regret. Jocelyn had developed a strong sense of scholarship over the four decades, as a student and as a teacher in the university setting. Her clinical work had been in the community and she developed a commitment to being involved in community health issues, and raising the profile of the nurse in areas of public health. Her chief regret was that she hadn't written and published more. She spoke of her husband's practice of writing for publication and then speaking to the publications, while Jocelyn wrote speeches without seeking to have them published.

So I've got a whole lot of speeches...To convert a speech into a publication is really difficult, but it is not difficult to convert a publication to a speech. So he [her husband] writes for publication first, sends them all around the place...for comment, and I don't do that.

I've never done that...Perhaps we have to start thinking like that...One of my regrets is that I have not written...It's not just you and I that get embarrassed when someone rewrites all over our 'baby', it's a human weakness –it's called 'dancing on our bones' at the moment – maybe we have to try and leave that as a legacy to the next generation – For heaven's sake write about what you are doing.

(Keith, 2:23)

We should take notice of this message from Jocelyn. New Zealand nurses must write about their experiences, their ideas, their research, and get their writings published. It is a key way we can contribute to the future, by documenting our work so that it is out there for debate, for information, and as a record of the value of nursing.

While Jocelyn had not published much of her writing, she had written many papers that have been inspirational for many New Zealand nurses. She was also very generous with access to her work and in relation to her reading. We discussed how she was constantly amazed by the treasures she had found in the library, which she visited several times a week, and her generosity in sharing material that she knew others were interested in, sending copies or references to others, a practice many more of us could follow.

Jocelyn identified two other issues as important. The first was seeking to raise the awareness of nurses so that they would promote health at every opportunity, an issue that was influenced by her career in community health, and her belief in the potential value of nurses and nursing to the health of New Zealanders.

The public trusts nurses to stand by them, and we need to be very careful to hang on to that, the commitment to care, to stand by someone while they make their decisions, to avoid creating dependency...Part of my legacy is [providing] awareness to nurses that they need to understand the dynamics of promoting health, the techniques of promoting health and their professional obligation to promote health in every possible opportunity.

(Keith, 2:16)

The promotion of health as nurse's special contribution was particularly important to Jocelyn, as it seemed to be to all nurses who have had the privilege of working in the community.

The second issue Jocelyn raised as a legacy was related to a commitment to the concept of 'excellence', a standard of excellence that nurses and nursing could aspire to. Excellence had been a topic of her thinking and writing for several years.

*[As Foundation chairperson of the NZNA certification committee]
I was able to see excellence in practice, and it was exciting, stimulating stuff. Nurses talking about making a difference, nurses demonstrating making a difference, nurses using research findings in practice, nurses actually doing research themselves and using those findings in practice and some of it was heart stopping, head challenging, marvellous, marvellous stuff.*

(Keith, 1:6)

The importance of setting a standard to guide nurses' practice, to commit to the work in hand, demanded a look at personal attitudes and beliefs. Jocelyn explored the importance of setting standards for herself – a role model for excellence in practice.

I've become increasingly intolerant of sloppiness in all its forms. If people are going to work with me or I'm going to work with them, I'm going to demand a high standard...It is not just for my purposes but it is because I think the future of the profession depends on it [excellence]. That sloppiness will undermine us. Division is one thing, but sloppiness puts people at risk...I've decided now that if I can't do something well I won't do it, I'll leave it to someone else. [I ask myself] can I make a real difference? So now when people ask me if I'll be involved with something, that's my standard as to whether I'm going to say yes or no. I don't just say 'yes' because it would be a nice thing to do, or because I owe it to someone to do it. If I can't do it well and do it with full commitment I'm not going to do it.

(Keith, 2:16-17)

In addition to setting personal standards, Jocelyn believed that the profession should also set a standard of excellence to enhance the reputation of the nurse and nursing, and to contribute the maximum possible to the health of the nation. This linked back to comments on standards when exploring accountability and responsibility. Excellence in practice was a standard that we could all attain, in every areas of practice.

It amazed me [on the Certification Committee] how I could recognise excellence in someone else's field about which I knew very little. It doesn't take long to start to become a connoisseur of excellence, and I could see excellence in the most modest part of a nurse's life and the grandest...I just don't have time for people who are not going to do it well. I'm too busy and [besides] I let the side down. I think the profession must have that same commitment – that either we do it well, and we maintain our reputation and we make the maximum contribution to people's health and wellbeing –

or we might as well fold up, shut up shop if we get known for 'easy/aisy' sloppy behaviour.

(Keith, 2:17)

Lubic cited in Schorr and Zimmerman (1988, p.235) had a reference to excellence in her guiding principles for practice “Nursing prepares you for excellence. Be proud you are a nurse.”

Jocelyn Peach also supported personal standards from a different perspective. She wanted to be remembered for the principles she held regardless of the context and that in working with others, she managed change in a way that respected people.

I want to be remembered as a principle centred leader. So regardless of all sorts of happenings and the power and the politics I want to be remembered for being principled, and that means managing change well, leaving people with dignity and a sense of going forward even though there's been an ending...for me that's quite important.

(Peach, 2:20)

The idea of a legacy included many concepts addressed in the previous theme chapters which was not surprising, as the participants were nurses who made a difference, and their lessons and legacies supported the power of the primacy of the nurse. The participants' legacies to note included the importance of recognising the potential for nurses and nursing, wanting nursing to be better than it was, and being educationally prepared to act whenever opportunities arose. The need to have a vision, enrolling others in the vision, and then making it happen. Legacies also included wanting others to capture the passion, the enthusiasm for nursing, setting standards of excellence and being proud to be a nurse.

Wise words

In the last section of this chapter I reveal some ‘wise words’ from the oral history participants. Wise words that apply to nurses and nursing in New Zealand as we move into the new millennium.

The idea for this particular revelation came from my reading about the ICN ‘watchwords’ established every four years by the incoming ICN President. The watchword was used as a ‘rallying call’ for the President’s term in office. They began in 1901 and have originated from nurses who were from all corners of the globe, a truly international perspective. It was fascinating to explore the watchwords over time (like Styles watchword ‘march’) demonstrating trends, and patterns of international concerns expressed by a single word. Words to express and/or guide the attitudes, beliefs, and responses of nurses world-wide.

Bergman (1981) described some of the past watchwords as nursing moved across a journey. Words that demonstrated our beginnings (‘courage’, ‘life’, ‘aspiration’), and words that expressed concern in a troubled world (‘peace’, ‘service’, ‘loyalty’, ‘faith’).

In the four decades of this study the watchwords have expressed concern to create strength within the profession (‘tenacity’, ‘flexibility’, ‘unity’), concern for the public good (‘accountability’, ‘justice’, ‘love’), and ideas for action – moving forward (‘march’).

Considering the list of words over ninety years provided me with a visual picture of our past, of nurses using the past to create ideas for their present, and more recently of nurses seeking to guide and inform the future. Building on the idea of international ‘wise words’ I have chosen some New Zealand ‘wise words’ by the participants as they shared their experiences and pondered the future of the nurse in New Zealand.

New Zealand nurses' 'wise words'.

Nurses can do anything if you set your mind to it you know. The sky is the limit.

Our future is in our hands.

*We have no right **not** to be stunning and gorgeous and fabulous and beautiful – but it is up to us.*

*You can make such a huge **huge** difference.*

Nursing is a terrible addiction. Nursing once you get hooked into it, once you've caught it, you can never let it go.

I believe in you [nurses], you matter, you are very important, and you've got a major contribution to make.

There will be opportunity for creative innovative nurses who have a good sense of self and who are not afraid of challenges and making decisions and driving new ideas.

It is because I am a nurse that I am in this position.

*We will always be there...the 21st century is just **ours**.*

Shaping health services for people is what it is all about.

Concluding remarks.

The primacy of the nurse over the four decades of this study finds its full realisation in this fourth square on the surface of the quilt, the final theme – creating a nursing future. While decision-making ability is critical, autonomy and accountability essential for professional growth, and energy, a driving force, needed to make things happen, the nursing profession could also gain insights from the oral and written texts to assist

guide and inform our future. The primacy of the nurse was revealed not only in these themes and processes, but also in the realisation that we are all working in a variety of ways towards creating our future.

The material presented in the chapter draws primarily on the oral history participant's accounts as they revealed how they were involved in helping to create the future. We learned about the process and how it works, from their carefully considered insights and reflections.

The oral history participants in the study, and the USA nurse leaders revealed several ideas that could be summed up in the sense of lessons and legacies. I gained an understanding of how in particular circumstances, times, or places, the participants felt they could make changes and I learned from their naming and describing what they saw as important in those specific circumstances. Understanding the 'how' – the way the participants used their primacy with such effectiveness to create a future - was included in the lessons the profession could learn. While we may not be able to anticipate with any certainty what events will happen in the future, what government might be elected, what policies might be promulgated, we can certainly learn the important attitudes and beliefs that underpinned nurses active responsiveness to the issues of the day that can ensure primacy of the nurse continues into the future.

Nurses can learn about the future from these participants, by their reflections and their stories. How they created their futures in their particular areas of practice. So when for example they talked about helping people manage in times of change we could see how a focus on attitudes that were positive, attitudes that looked for opportunities, attitudes that built on small successes were more likely to create a future that ensures the primacy of the nurse, than people with attitudes that were apathetic, who didn't look for opportunities, or make choices. This whole chapter is built around the premise of what worked, what made a

difference to provide New Zealand nurses with a guide that could inform our future.

The lessons from the participants outlined that, for them, the meaning and understanding of important concepts developed over time, and that with more experience, more time to consider the implications, the significance of what was important to assist nurses and nursing grow professionally became clearer. The participants' experiences revealed their beliefs that to be actively responsive to the issues of the day they needed to be well prepared educationally to enable them to seize opportunities. While it was helpful to be in the right place at the right time, they demonstrated flexibility when choices needed to be made. The importance of resilience and persistence were mentioned again realising that change takes time, and that the time for a particular action needs to be the right time for all concerned. To be effective the participants often needed patience, resilience and to find different ways to act to ensure they finally reached their goal.

By understanding what it was that they contributed over time, and how they created the future by their actions, we can understand something about our present, how and why nurses and nursing in New Zealand are like they are. The legacies revealed by the participants enabled us to see how these nurses helped to create our present, and provided evidence of the power of primacy – the primacy of the nurse in New Zealand over this period.

We understand the sense of the possibility of making a difference and effecting change so that, in the sense of legacy, we not only have the knowledge about what has been achieved, but also the realisation that we in **our** present can use our skills and knowledge to help create a future for the next generation. There is this sense of 'continuous existence' and the responsibility we all have in the passage of legacies from one generation

to the next. We can learn that lessons and legacies contribute not only to our professional development as individuals or within the profession as a whole, but that there is this process, this passage, an ongoing journey into our future.

We can note that while recognising that effective decision-making, within a context of autonomy and accountability, supported by active responsiveness in the sense of a driving force, can make a difference and add to the contribution nurses make to health care, we cannot stop there. To ensure the primacy of the nurse, we need more, we need a future focus, a vision in terms of the future of the profession and the future of practice, and we need to take action to move forward towards that focus. Indeed I would suggest that the evidence from the written and oral texts suggest that this is our purpose, our responsibility. We need to ensure the continuation of the primacy of the nurse to fulfil our social mandate and contribute to the health of the peoples of New Zealand.

It is exciting to realise that over these four decades the texts revealed that when nurses **have** acted and seized the opportunities, nurses and nursing did make a difference, a contribution that evolved and developed over this time. The stereotypical beliefs of the nurse as quiescent, as handmaiden, as just working from day to day without developing, do not hold true when you explore the big picture, the big trends. The evidence to support the idea of primacy of the nurse was there in so many aspects of practice, and in examples of articulate, confident nurses able to market the potential value of nurses and nursing.

There is, however, a greater potential. International nurse writers and leaders in WHO and the ILO consistently talked about the potential of nursing worldwide, the potential to make the world a better place. Nurses themselves nationally and internationally have talked about this potential, the driving force that nurses and nursing could be if only we 'got our act

together’(note the implication of ‘action’). It is interesting to ponder about when this potential might be realised, when the ICN vision for the future - of nurses united, speaking with one voice, and working together to shape a future of healthy people in a healthy world – could become the reality for nurses and nursing in New Zealand.

For many of the participants and the USA nurse leaders, their professional nursing life has been a journey, a journey informed by the past that created their present at that moment in time. They could also see what needed to be done in the future. By bringing past insights and observations through to the present, and drawing on the lessons of the past, possibilities for the future could be revealed. These nurses have stepped out, and through their own actions have experienced the potential to contribute, because of the clarity of their vision and their active responsiveness. Their actions demonstrated the power of the primacy of the nurse.

We have a responsibility to pick up the mantle – we can all make a difference in our own area of practice, and we owe it to future generations to do so.

Chapter Eight: The primacy of the nurse: Enduring over time

In revealing the primacy of the nurse in New Zealand: 1960s –1990s: attitudes, beliefs and responses over time – I have premised the work on the argument that we can learn from the past through the written texts and the voices of nurses. The primacy of the nurse is central to the development of the profession as we move into the new millennium. The specific influence and contribution of the individual nurse and the profession as a whole, enabling nurses and nursing to move forward.

The four theme chapters have been presented in order of development from the wider context towards the perspectives of the oral history participants. The first two theme chapters revealed the overall movement in the profession characterised by how the profession made decisions over the four decades, how the profession grappled with and exercised professional autonomy and accountability during this period in our history. The latter two themes revealed something more of the ‘insideness’ of that, relying particularly on the strength of the participant’s accounts. Through these accounts we were able to gain some sense of how a number of nurses in New Zealand over the four decades were able to exercise primacy and create change by acting as drivers, making a difference and leading developments. The four chapters sequentially deepen our understanding. The themes depicted by the four squares on the surface of the quilt, are inter-related, and of equal value and importance in building up the concept of primacy of the nurse in New Zealand 1960s-1990s.

The primacy of the nurse becomes clearer by exploring underneath the actual event, clarifying the context surrounding the event, and asking the ‘why’ and ‘how’ questions. While written texts enabled us to read about

an event in the context of the day, they rarely provided us with the meaning of those events, the subjective realm, the previously unavailable information that can be revealed only by the persons who were involved or present at the time.

The voices of the oral history participants enabled the attainment of a diversity of both individual and professional perspectives of major events; and the exploration of attitudes and beliefs underpinning responses to such events. By reading about events over the period 1960 - 1990s, and listening to the participants, I was able to see big changes, to construct a picture of what was going on, what nurses did, and how and why they responded in particular ways. What assisted them to make progress? What were the barriers?

Exploring the source material raised important questions such as - what really made the difference? What helped the profession to grow? It was very clear that the key influencing factor was the active responsiveness of the nurse, the nurse as an individual, in small groups, in organisations. The primacy of the nurse is articulated by active responsiveness, the ability to respond to a changing context whether it be to large events like the transfer of nursing education or to smaller events such as the introduction of primary nursing into a particular unit.

The revelations in this thesis can help nurses to understand the concept of primacy, to understand how nurses effected change in the past, and learning from these experiences, to understand how each individual nurse could make a positive contribution. Indeed I believe we have a responsibility to do so.

As individuals we could learn that we could all make a difference and effect positive change, everyone of us. We don't have to wait until we are in positions of authority - the Director of Nursing or Head of a nursing school. The oral history participants clearly demonstrated that bringing

about change was possible not only from positions of ‘power’ (the ‘power of authority’) but occurred for them at times when they were really clear about what they wanted to do about making nursing better than it was. These nurses created change when they were teachers, charge nurses, post graduate students, nurses in clinical practice, and they continued to contribute throughout their careers – success leading to further success.

Each nurse in practice needs to ask herself the ‘how’ question – “How can I make a difference?” In answering that question there are three key things we need to consider revealed by this study. . First, to contribute and make a difference we need to be willing to make effective nursing decisions. Movement forward is all about people making decisions. Crisp timely decision-making is identified as an important active response to recognising a need for change. There are many ideas in this account to help understand the ‘what’, the ‘why’ and the ‘how’ of decision-making and that our attitudes and beliefs influence how we respond within the parameters of our practice. The processes we use to make decisions are the same in both the small decisions as well as the big decisions.

Secondly to make a difference and effect change, the study revealed that having made decisions, nurses needed to feel free to choose to make decisions and to be accountable and responsible for decisions relating to nursing matters. The evidence suggests that if we do not accept that nurses need to make nursing decisions, and keep running off asking for permission from other people, others will make decisions for us. Nurses need to grasp and control nursing and led our own destiny ensuring the primacy of the nurse. We need to be accountable for our responses, for the decisions we make and the actions that follow within a context of professional autonomy and partnership.

Thirdly to make a positive contribution nurses need to acknowledge that making nursing decisions and being accountable for them is not enough to

ensure the primacy of the nurse. We need to move forward, to create change, to be actively responsive to the issues of the day. We can note from the written and oral texts that nurses have moved forward since nursing began, and that over the time period of this account examples of individual nurses and the profession moving forward have been revealed. We can look back with huge pride and amazement at the progress that nurses have made, and ask ourselves the question, if this has been possible in the past why should it stop being possible? To help us keep that momentum, that idea of nursing as ‘a living force of continuous existence’ we need to be committed to making a difference, to taking action to move forward, to reach our potential, so that **every** nurse contributes to the health of the peoples of New Zealand.

Referring back to the question ‘How can I make a difference?’ we can again be informed by the experiences of the oral history participants and the USA nurse leaders, the lessons they learned over time, the legacies of their contribution, what worked for them when they were involved in helping to create our future. We are left with a sense of understanding within this period of time in New Zealand, 1960s-1990s, of how absolutely significant the primacy of the nurse had been. How nurses attitudes and beliefs impacted on their responsiveness, and influenced both individuals and the professions development, its practice, its goals, indeed its whole shape in these four decades.

The written and oral texts also revealed the potential of the nurse in ways that every nurse can identify with because we are all expected to make decisions, expected to be accountable and professional, and to make a contribution. The participants revealed as part of their legacy the sense of this potential, the possibilities that exist of how nurses could continue to use their primacy. This thesis demonstrated the evidence of primacy – evidence of the potential for creating a positive future for nurses and nursing.

While the findings of this study are limited to exploring the oral history participants and stories from the written texts, the research reveals some important developments and trends within New Zealand's nursing history. This thesis is not an historical account of events, it is an interpretive exploration of a wide variety of written and oral texts that enabled new understandings of broad trends and patterns to emerge related to the primacy of the nurse. The ability to use a series of contrasts enhanced meaning and understanding as big picture/little picture examples demonstrated similar attitudes, beliefs and responses. Similarly the international/national trends showed how, in a global sense, the potential for primacy of the nurse is world-wide.

Rather than seeking merely to understand why things did or did not happen, I used an approach that sought to understand by investigation. The findings have included the 'what', 'why' and 'how' involved in nurses making a difference and contributing to the progress of the profession. Further research could pursue more of the assumptions and parameters of the study.

This study explored national/international perspectives that had affected the R.G.O.N./R.Cp.N. It would be interesting to explore regional or local perspectives and the perspectives of other groups of nurses (e.g. the R.P.N.) or Midwives regarding primacy. The period of the study was situated in New Zealand of the 1960s-1990s. Further exploration of the concept of primacy of the nurses in a different time period or in more detail over a single decade e.g. the 1990s would add to our understanding.

More in depth analysis of some of the key concepts may be revealing – the concept of primacy of the nurse, and the attitudes and beliefs that underpin primacy. Within decision-making we could further the exploration of attitudes of confidence and self-belief, the significance of resilience. Autonomy and accountability could be examined in relation to

autonomy within a team, partnership, or collaboration. We could also explore attitudes that act as barriers to progress, attitudes and beliefs that do not contribute to the concept of the primacy of the nurse. Such attitudes and beliefs might include apathy, resistance to change, and lack of commitment.

As I constructed the account, I was also aware that there were many fascinating stories to be told behind the events of the day. For example, the story of La Provocateuse, the rise and fall of the Division of Nursing in the Department of Health, the developments of the clinical practice role for the NZRN.

Those who may find this account helpful include nurses internationally who are interested in developments in nursing in New Zealand or the concept of the primacy of the nurse. Nationally nurse administrators and nurse leaders could use the lessons and legacies revealed by the participants and the USA nurse leaders, to inform their own responses, particularly in relation to making progress and moving the discipline of nursing forward.

My biggest hope is that contemporary nurses in practice will find this study helpful when considering aspects of their practice, as every nurse can make a difference and a positive contribution if we understand 'how'.

Summary of the journey

A lifelong interest in and commitment to nurses and nursing led to the start of this journey. The four decades of my working life had seen so much change, so many opportunities and choices, so many 'ups and downs'. I wanted to know more. I wanted to understand why and how these changes had taken place and in particular to explore the changes in attitudes and beliefs that underpinned nursing responsiveness.

I am convinced that the past has lessons for us all. Lessons that we can search out to guide us in both the present and the future if we are going to interpret, understand and give meaning to the context of the richness of our history. The women participants in this study have provided nurses and nursing with an extraordinary opportunity to study and learn from their diverse pasts. They have clearly stated their views, their perspectives their attitudes, beliefs, and responses over time. In discussing the lessons learned they have revealed the lessons as legacies they wish to make available to you and me.

I want nurses of the future to know what their forebears thought, what they believed, and why they responded in particular ways. I want nurses of the future to understand and value the diversity of nursing, and the different perspectives of events. I have been involved in nursing education and politics over much of the time of this study and had made certain assumptions regarding the influencing factors impacting on nurses and nursing over this period. In the initial research proposal while acknowledging the input nurses had made over time, there was a strong assumption on my part that external forces were more influential and they would be the major factors to emerge from the data. This was not the case.

Indeed the findings were for me much more exciting than my initial assumptions. The primacy of the nurse was such a strong outcome that my pride in nurses and nursing was reinforced and my energy and commitment to share the findings with others strengthened.

My initial approach to the journey was to gather information from the written texts to create a context that would set the scene. Because our attitudes and beliefs influence our responses to any given situation it was important for me to consider what attitudes and beliefs underpinned the responses that occurred over time. This led to the conclusion that an exploration of nurses' attitudes and beliefs would best be done by

interviewing and talking with nurses. The question was – what process and which nurses to interview?

The choice of nurse participants was influenced by the need to move from the past through the present into the future. I needed to have access to nurses who worked over much of the time of the study, who could assist me gain meaning and understanding about what they did in the past that was effective and moved nursing forward. I also wanted to explore ‘why’ they responded as they did and especially ‘how’ they made a difference. I could also ask these nurses what they learned from the past that they pulled through and used in the present, and how their experiences guided and informed their future. It was also important to talk with nurses who were knowledgeable, with a profound and central grasp of the cultural world of nursing.

I am especially grateful to the twelve participants in my study. Nurses who were generous with their time, sharing with me aspects of their personal lives and their recollections of the how they responded to major events over the period. I am particularly humbled by their trust enabling me to use their real names and in some instances very personal reflections about the significant impacts in their nursing lives.

My own learning through an ongoing interpretation of the source material has continued throughout the period of the study leading to a heightened awareness and understanding of the important potential of the nurse and nursing. There is overwhelming evidence from the experiences revealed in the written and oral texts that just as our past has been the result of the action or inaction of both the individual nurse and the profession as a whole, so the present and the future of the nurse and nursing is in our hands and will be influenced by our responsiveness.

We need to build on the respect the public of New Zealand accords the nurse, and seize the moment to effect change every time such an

opportunity arises. Every time a nurse has a choice to make she should have the confidence to make a ‘crisp timely’ decision, a decision that she can accept responsibility for, and that will improve the health outcomes for the people of New Zealand. We need a critical mass with a commitment to nursing, and a passion for nursing, so that the environment in which we work is positive, supportive, and not one in which a victim mentality or apathy can thrive.

Throughout the period of putting this account together I never lost interest, I remained excited, fascinated, and proud of the New Zealand nurse. I feel privileged to be part of a profession that has the potential to make an important contribution to the health of our nation.

There is no one else but the nurse who holds the present and the future for nurse and nursing in her hands, no one else to thank or blame. While the context can influence our attitudes, beliefs and responses, the primacy of the nurse is clear, and this study resolutely places the primacy of the nurse in New Zealand in its correct place in the forefront of the decades 1960s-1990s.

Appendices

Appendix One: The participants

The oral history participants in this study were:

Margaret Bazley

Marie Burgess

Mia Carroll

Jocelyn Keith

Nan Kinross

Elizabeth Lee

Anne McDonald

Lee Mathias

Ann Nightingale

Jocelyn Peach

Yvonne Shadbolt

Sally Shaw

Appendix Two: Participants consent form

1. Participant consent form

Project title for studies involving interviews.

“Landmarks and likely futures – the role of the nurse in NZ.”

2. Investigator details

Gay Williams

Fulltime student

Qualifications – Academic – BA, Dip Soc. Sci.

Professional – RGON. JP.

Phone (09) 524 7221 Fax (09) 5247257 email gayw@cybernet.co.nz

3. Venue

The interview will where possible take place in the home of the participant

4. Description of aims and purpose

To obtain information from the documents (on public record) and from key participants that will assist identify historical themes, trends and landmarks that have impacted on the role of the nurse in NZ from 1960 onwards.

Nurses in New Zealand have not documented key events in their history to a great extent. The period from the 1970s onwards saw major changes in the education and clinical practice of the nurse in NZ and the restructuring of the Health service from 1988 onwards has had a major impact. Understanding and interpretation of key events linked to changes in the role of the nurse needs to be documented as part of NZ history, Nursing history, and NZ women's history.

5. Inconvenience

I estimate that a period of two hours would be necessary to set aside for the structured taped interview.

6. Confidentiality

Any information obtained from the participants of a confidential nature will not be disclosed or made public without the express permission and approval of the participant. Any reference to third parties that is not already available in the public domain will not be disclosed without the express permission from the third party concerned

Prior to the use of any data a copy of the tape and highlights of the content to be used by the researcher will be sent to the participants. The participants will be asked to confirm the accuracy of the content to be used by the researcher. An opportunity to withdraw any information will be provided to the participants.

7. Storage of the tapes

At the completion of the project, the researcher will either store the tapes as part of the NERF Oral history project, or return the tape to the participant according to the participant's wishes.

Statement to be signed in the presence of one of the investigators and, where possible to be witnessed.

I have read the consent form and have had the opportunity for discussion with.....

I know that I may withdraw from the study at any time and I understand that this withdrawal will not adversely affect my future health care.

I understand that this study has been approved by the Victoria University of Wellington Human Ethics Committee.

I agree to take part in this study.

Signed.....(participant).....(date)

.....(witness)(date)

Witness name.....(print name)

Statement by investigator:

I have discussed with(participants name)
The aims of and procedures involved in this study.

Signed.....(investigator).....(date)

Three copies required: 1 retained by participant; 1 retained by investigator; 1 for the records.

Appendix Three: Name changes since the inception of NZNO

The New Zealand Nurses Organisation has had a number of name changes since it's inception in 1909.

New Zealand Trained Nurses Association (NZTNA) from 1909 – 1934.

New Zealand Registered Nurses Association (NZRNA) from 1934 – 1971.

New Zealand Nurses Association (NZNA) from 1971 – 1993.

New Zealand Nurses Organisation (NZNO) from 1993 – present.

In referring to NZNO in the text I have chosen to use the term in use at the time an event is described. For example for an event between 1971 – 1993 I would use NZNA.

Appendix Four: The New Zealand Nursing Journal:

‘Kai Tiaki: Nursing New Zealand’ is the current title of the journal published by the New Zealand Nurses Organisation.

Miss Hester Maclean, Assistant Inspector of Hospitals and Deputy Registrar of Nurses (and Midwives) founded the Journal in 1908. She saw the need for some medium of communication for nurses in New Zealand, and in her book she describes the enthusiastic reception she received from nurses and their friends when she suggested a journal for nurses and offered to be the editor.

The proposal was enthusiastically received, so I immediately went to work communicating with the matrons of the chief hospitals, and nurses in the different centres, asking them to become subscribers. A good response was received. I had the assistance of a young man, a member of a firm of publishers, in making arrangements for printing and distribution, and in January 1908, the first quarterly number appeared.

(Maclean, 1932).

The first title for the journal was ‘Kai Tiaki’. In searching for a distinctive title Miss Maclean made enquiries for some Maori word that could convey the idea of caring for the sick. The Government interpreter suggested the term ‘Kai Tiaki’ meaning the ‘watcher’ or the ‘guardian’.

The journal was called ‘Kai Tiaki’ until 1930 when the name changed to ‘The New Zealand Nursing Journal (Kai Tiaki)’.

This change of title reflected the changed ownership of the journal, which had been the personal property of Miss Maclean until in 1923 the

Wellington branch of the New Zealand Trained Nurses Association (NZTNA) negotiated with Miss Maclean to purchase the journal. The National body of the NZTNA subsequently purchased the journal in 1924.

Miss Maclean remained editor until 1931 the year before her death.

The title The New Zealand Nursing Journal ‘Kai Tiaki’ remained unchanged until 1993.

At this time the NZNA and the NZNU (An organisation founded by NZNA and separated out as an independent entity in 1987) amalgamated to form the New Zealand Nurses Organisation (NZNO). In the spirit of a new beginning the title of the journal needed to be changed. The decision was made to call the journal Nursing New Zealand, and to remove the words Kai Tiaki from the journal title. This decision was not well received by members of the new organisation and so in 1995 the journal; was given it’s current title Kai Tiaki Nursing New Zealand.

Titles of the *NZNJ* over time.

Date	Title
1908–1930	Kai Tiaki.
1930-1993	The New Zealand Nursing Journal Kai Tiaki
1993–1995	Nursing New Zealand
1995-	Kai Tiaki: Nursing New Zealand.

Appendix five: Nursing education in New Zealand: Some significant dates

The dates listed below provide the reader with an overview of the significant dates in the progress of nursing education in New Zealand throughout the nineteenth century.

Date	Nursing education events.
1912	Dr J.C. Pabst of the honorary medical staff of the Auckland Hospital in a speech to mark the opening of the nurses home, urged the University of New Zealand to institute a degree in nursing to give nurses 'full professional rank'.
1925	A university degree programme began in Otago intending to be of five years duration of which 2 years would be spent in hospitals. Shortage of funds and attitudes relating to the status of nurses and the higher education of women forced the closure of the school in 1927.
1928	Full time advanced study for Registered Nurses began in Wellington at the New Zealand Post Graduate School, renamed the School of Advanced Nursing Studies (SANS) in 1970. From 1968 students were required to include specified papers from Victoria University of Wellington in their courses. The school closed in 1978 with the establishment of Advanced diploma courses in selected polytechnics commencing in 1979.
1958	Obstetric experience introduced into the general curriculum leading to the registration of the general and obstetric nurse.
1964	The Nurses and Midwives Board (renamed the Nursing Council of New Zealand in 1972) accepted a plan for "basic" nursing education proposing that by 1970 there should be three main education streams: a university degree programme to prepare nurses for the most responsible posts in nursing, a three year comprehensive programme to prepare nurses for first level positions in generalised patient care; and a one year community nursing programme to prepare nurses to provide "basic" nursing service requiring a lesser degree of clinical responsibility.

1965	Alma E Reid, Director of Nursing at McMaster's University, Canada prepared a report 'The Reid Report' financed by the University Grants committee on the role of universities in nursing education. Her recommendations included the establishment of a 'basic' degree programme.
1965	Psychosocial concepts introduced into the general and obstetric curriculum
1966	World Health Organisation (WHO) WHO Expert Committee on Nursing, 5th report [World Health Organisation Technical Report Series, No 347] was promoted by ICN.
1969	'A Review of Hospital and related Services in New Zealand' published by the Department of Health made recommendations on nursing education including proposals that one quarter of Registered Nurses should receive their education in a University School of Nursing and the remaining three quarters within the polytechnics.
1971	A World Health Organisation short-term consultant was requested by Government to study New Zealand's nursing education system. Her report 'An improved system of nursing education in New Zealand' was perceived by many as the trigger for change in the transfer of nursing education from the Hospital Board schools to the Tertiary education sector.
1973	<p>Pilot schemes for three-year "basic" nursing education courses were established in two polytechnics. These three-year 'Comprehensive' courses combined general/obstetric, psychiatric, and psychopaedic components into one course leading to a new category of 'Comprehensive' registration.</p> <p>Bridging courses were established to enable hospital trained single registration nurses (psychiatric, psychopaedic, and gen. /obstetric) to become comprehensive nurses prepared to practice nursing in all settings.</p> <p>Nursing education degree and diploma programmes began at Victoria and Massey Universities for the R.N.</p>
1978	Government policy established to transfer nursing education of the Registered Nurse to the system of general tertiary education. The enrolled nurse programme was to continue in the hospital setting.
1978	The School of Advanced Nursing Studies closed in 1978 with the establishment of Advanced diploma courses with a clinical focus planned to commence in selected polytechnics in 1979.

1980	Nursing Education Review and Advisory Committee (NERAC) established to advise the Minister of Health on both 'basic' and 'post basic' nursing education.
1982	A Nursing Manpower (later renamed 'Workforce') planning Committee was established in 1982 and given the task of preparing a nursing manpower plan by 1985 to guide student intake numbers. The interim conclusions in 1983 recommended that the total intake into all three year programmes or courses be held within the range of 1,200 – 1,500.
1986	Between 1973 and 1986 the number of polytechnics offering Comprehensive nursing courses increased from 2 schools to 15 schools.
1986	The Department of Health promoted a Review of the Preparation and Initial employment of nurses. To review issues and develop strategies for future action. Included in it's recommendations was the need for hospital-based programmes leading to registration to be phased out within an established time frame
1988	Pending a decision from the Auckland Hospital Board, the transfer of nursing education was in its final phase. All other Hospital schools had closed or were completing their last intakes..
1990	Amendments to the Education Act (1990) enabled degree programmes to be established in tertiary settings other than Universities.
1995	All Schools of Nursing in New Zealand now offered three-year degrees leading to registration as a Comprehensive nurse.
1997	The Auckland Technical Institute began a multidisciplinary Masters degree programme for health professionals.
1998	Medical schools in Auckland Christchurch and Dunedin were involved in some way in nursing education

Appendix Six: Modes of clinical practiceThe modes of clinical practice used over the four decades.

Mode of practice	Description
Task oriented nursing (Functional nursing)	<p>This mode of practice is effective when a large part of the workforce is transient, or unqualified. And the abilities of the staff are diverse. Each person is assigned tasks according to their abilities. It is also used where there are few caregivers and tasks can be assigned to individuals in the interests of time and expediency.</p> <p>The priority is to get the work done and there is often little time to explain why things are done in a particular way. The linking of theory and practice is not a priority. Rules and traditional ways of work are common.</p>
Team nursing	<p>Groups (e.g. Registered Nurses and students) work together to meet a group of patients individual needs rather than specific tasks to be accomplished.</p> <p>The varying levels of skill and experience of the staff available can be matched with the needs of the patients they are caring for.</p> <p>To be effective, team nursing requires care plans to provide for continuity of patient care, and regular team conferences to share information about the patients and to work out care plans</p>
Patient assignment	<p>The allocation of a patient or group of patients to one nurse for the duration of a duty period.</p> <p>The focus is on the nurse–patient relationship that develops to ensure that the patients needs are met.</p>
Primary nursing	<p>A patient is assigned to one nurse who plans the 24 hour care for the patient for the duration of the patient's stay in hospital. There is a focus on the development of a care plan that can be followed by other nurses caring for the patient when the primary nurses is not on duty.</p>

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